

# PPACA IMPLEMENTATION: UPDATES FROM CMS AND GAO

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## HEARING BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED THIRTEENTH CONGRESS SECOND SESSION

JULY 31, 2014

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## **PPACA IMPLEMENTATION: UPDATES FROM CMS AND GAO**

**THURSDAY, JULY 31, 2014**

HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,  
COMMITTEE ON ENERGY AND COMMERCE,  
*Washington, DC.*

The subcommittee met, pursuant to call, at 9:19 a.m., in room 2123 of the Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Members present: Representatives Murphy, Burgess, Blackburn, Gingrey, Harper, Gardner, Griffith, Johnson, Ellmers, DeGette, Braley, Schakowsky, Castor, Tonko, Yarmuth, Green, and Waxman (ex officio).

Staff present: Mike Bloomquist, General Counsel; Sean Bonyun, Communications Director; Matt Bravo, Professional Staff Member; Leighton Brown, Press Assistant; Karen Christian, Chief Counsel, Oversight and Investigations; Noelle Clemente, Press Secretary; Brad Grantz, Policy Coordinator, Oversight and Investigations; Brittany Havens, Legislative Clerk; Sean Hayes, Deputy Chief Counsel, Oversight and Investigations; Emily Newman, Counsel, Oversight and Investigations; Jean Woodrow, Director of Information Technology; Phil Barnett, Democratic Staff Director; Peter Bodner, Democratic Counsel; Brian Cohen, Democratic Staff Director, Oversight and Investigations, and Senior Policy Advisor; Lisa Goldman, Democratic Counsel; Elizabeth Letter, Democratic Press Secretary; Karen Lightfoot, Democratic Communications Director and Senior Policy Advisor; and Matt Siegler, Democratic Counsel.

### **OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA**

Mr. MURPHY. Good morning. I convene this hearing of the Subcommittee on Oversight and Investigations to review the implementation of the Patient Protection and Affordable Care Act. Our first witness this morning, Mr. Andy Slavitt, the Principle Deputy Administrator at the Centers for Medicare and Medicaid Services. This is Mr. Slavitt's first testimony as a CMS employee, but not his first appearance before this subcommittee. Some of you may recall that Mr. Slavitt appeared before us last October to testify on behalf of one of the contractors who built the Healthcare.gov site. So welcome back.

Our ongoing concern about Healthcare.gov is one of the reasons that we are holding this hearing today. Exactly 1 year ago this

week, members of this committee will remember that we heard from CMS Administrator Tavenner who told us that Healthcare.gov would be ready on October 1. We were told that it would work, everything we be fine. And later, we found out that that wasn't quite the same thing. In fact, the contractors told us the same thing, that it would be working.

Our reviews of the Web site were brushed aside. But we know how our fears of a massive flop were well-founded. The rollout of the Affordable Care Act was an unmitigated disaster. I think everybody agrees with that.

So, Mr. Slavitt, we are hoping to hear from you today candidly and honestly about how things are progressing. And, frankly, we hope we hear with the same candor from you as an administration official that we heard last fall when you testified on behalf of QSSI, the company that built the hub for Healthcare.gov.

Mr. Slavitt's new role also comes at an opportune time for the administration to address the systemic problems that led to the Healthcare.gov disaster. After Mr. Slavitt's testimony, we will hear from William Woods with the Government Accountability Office. Today, the GAO has released a review of the failed October 1 launch of Healthcare.gov, confirming what this committee learned during its own review of the Web site, the administration didn't have the expertise, couldn't meet deadlines and didn't have the leadership or organizational skills to manage this massive undertaking. And GAO also has given us a price tag for this boondoggle, a broken Web site that the President promised would be as easy to use any an ecommerce site, cost the taxpayers nearly \$1 billion. That took a lot of taxpayers' money from their hard-earned paychecks to come up with that 1 billion, and many taxpayers aren't happy about that.

We will also hear from the GAO that these costs are still going up. Some of my colleagues may whine and complain that we are spending too much time examining the failed Web site launch. I am not surprised. They don't want to talk about it. But the reality is these problems are still playing out, and may impact this fall's open enrollment period.

We still do not know if the administration has a system in place capable of handling inconsistencies, inaccurate subsidies, web security, or whether CMS will ever put in place a functioning payment system.

We will ask today about the Healthcare.gov contracts and the GAO report. But as we head into open enrollment this fall, patients and families need to know how this law will affect them because, each day, the ACA is making our healthcare system more expensive, fragmented, and restrictive.

Earlier this summer, insurers were required to notify the administration plans for premium rates in 2015. We hope that witnesses today will provide information on the rates that have been submitted, when the public will know them with enough time to plan for their purchase, and whether the public will ever see \$2,500 in savings that the President promised.

Speaking of promises, we also want to know if Americans will be able to keep their doctor and if they were able to keep their plan if they liked it. Earlier this year, this committee heard testimony

from representatives of the insurance industry who noted that the requirements in the healthcare law required the cancellation of millions of policies. We hope to hear whether the administration predicts widespread cancellations and uncertainty again this fall.

And it is not only individual plans that we are concerned about. Last week, the IRS finally began releasing information related to the enforcement of the employer mandate. This may be surprising to many. The administration has after all delayed this several times. But it certainly raises questions about what will happen when one of the law's most controversial pieces finally goes into effect.

Finally, I remain concerned about the overall impact of this law. Millions of Americans had their health insurance cancelled because of the law only to find that the plans they are now forced to buy are much more expensive in premiums, copays, deductibles or all the above. Some people may qualify for subsidies and others do not. At the same time, the law's massive cost and destructive impact on the economy will continue to be felt for years.

I again thank both the witnesses for testifying.

[The prepared statement of Mr. Murphy follows:]

#### PREPARED STATEMENT OF HON. TIM MURPHY

Our first witness this morning is Mr. Andy Slavitt, the Principal Deputy Administrator at the Centers for Medicare and Medicaid Services. This is Mr. Slavitt's first testimony as a CMS employee, but not his first appearance before this subcommittee—some of you may recall that Mr. Slavitt appeared before us last October to testify on behalf of one of the contractors who built HealthCare.gov.

Our ongoing concern about HealthCare.gov is one of the reasons that we are holding this hearing today. Exactly 1 year ago this week, members of this committee will remember that we heard from CMS Administrator Tavenner, who told us that HealthCare.gov would be ready on October 1. The contractors told us the same thing. Our reviews of the Web site were brushed aside, but we know how our fears of a massive flop were well-founded. The roll-out of the Affordable Care Act was an unmitigated disaster. So, Mr. Slavitt, we hope to hear from you today about how things are progressing—and frankly, we hope to hear the same candor from you as an administration official that we heard last fall when you testified on behalf of QSSI, the company that built the hub for HealthCare.gov.

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Some of my colleagues may whine that we're spending too much time examining the failed Web site's launch. I'm not surprised they don't walk to talk about it, but the reality is these problems are still playing out and may impact this fall's open enrollment period. We still do not know if the administration has a system in place capable of handling inconsistencies, inaccurate subsidies, or whether CMS will ever put in place a functioning payments system.

We will ask today about HealthCare.gov contracts and the GAO report, but as we head into open enrollment this fall, patients and families need to know how this law will affect them because each day, the ACA is making our health care system more expensive, fragmented, and restrictive. Earlier this summer, insurers were required to notify the administration of plans for premium rates in 2015. We hope the witness today will provide information on the rates that have been submitted, when the public will know them with enough time to plan for their purchase, and whether the public will ever see the \$2,500 in savings that the President promised.

Speaking of promises, we also want to know if Americans were able to keep their doctor and if they were able to keep their plan if they liked it. Earlier this year, this committee heard testimony from representatives of the insurance industry who noted that the requirements in the health care law required the cancellation of millions of policies, and we hope to hear whether the administration predicts widespread cancellations and uncertainty again this fall.

And it is not only individual plans that we are concerned about. Last week the IRS finally began releasing information related to the enforcement of the employer mandate. This may be surprising to many—the administration after all has delayed this several times—but it certainly raises questions about what will happen when one of the law's most controversial pieces finally goes into effect.

Finally, I remain concerned about the overall impact of this law. Millions of Americans had their health insurance cancelled because of the law, only to find that the plans they are now forced to buy are much more expensive. Some people may qualify for subsidies, others do not. At the same time, the law's massive cost and disruptive impact on the economy will continue to be felt for years. I again thank both the witnesses for testifying and now recognize the ranking member for 5 minutes.

Mr. MURPHY. And now recognize the ranking member for 5 minutes.

**OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO**

Ms. DEGETTE. Thank you so much, Mr. Chairman. Well, I have got to say, I don't really think we could go on August recess without having another hearing on the Affordable Care Act, because this is now the twelfth one we have had in the last 10 years. As I have been saying the last couple years, the ACA Oversight is a really important topic, but I would feel a whole lot better if we were actually doing oversight on what is happening now with the ACA instead of just rehashing old issues over and over again.

You are right. We will stipulate the rollout of the ACA was an unmitigated disaster. But I guess I would like to know how long we are going to keep beating this drum? Because when you look at what has happened since the unmitigated disaster of the rollout, things are actually improving. And just about every prediction that was made about the law has turned out to be wrong once we got going. So I think we should spend our time trying to figure out how to make the law work even better for the millions of Americans who are now enrolling and getting health insurance.

So in the last year, we had hearings where the majority insisted that Americans would be hit by insurance rate shock. Instead, the majority of new enrollees in ACA coverage are paying less than \$100 a month. The majority insisted that the broken Healthcare.gov Web site would never be fixed, but thank goodness it was. And millions of Americans used it to sign up for coverage. They insisted that many Americans would not pay for coverage once they signed up. But the insurers all came in here and told us that was not correct that people in fact were paying. They insisted that 2015 premiums would skyrocket. But again, that is proving not to be true. In fact, in many cases, enrollees will be able to reduce their premiums next year. They insisted that Americans did not want or need health insurance coverage. But over 20 million Americans have received coverage under the ACA, and the un-insurance rate has dropped precipitously since January. The vast majority of new enrollees are happy with their plans.

Now, these are important facts, Mr. Chairman. And in the interest of making the hearing as fact-based as possible, I want to talk about some fact sheets released earlier today by the Energy and Commerce Democratic staff on the benefits of the Affordable Care Act in every congressional district in the country. I would ask unanimous consent to enter the fact sheets for each committee member into the record, Mr. Chairman.

Mr. MURPHY. Without objection, so ordered.<sup>1</sup>

Ms. DEGETTE. Thank you. And I just want to talk about some of the benefits of the law in my home State of Colorado.

In Colorado, there are 240,000 State residents who were previously uninsured but who now have quality affordable health coverage because of the Affordable Care Act. In Colorado, our uninsured State residents has declined by about a third. Almost 2.1 million people in Colorado, including 460,000 children and 860,000 women, now have health insurance that covers preventative services without any copayments or deductibles. Fifty thousand young adults in Colorado retained health coverage through their parent's plans. More than 40,000 seniors have received Medicare Part D drug discounts worth \$118 million. 1.8 people in Colorado are protected by ACA provisions that prevent insurance companies from spending more than 20 percent of their premiums on profits and administrative overhead. Because of these protections, over 210,000 individuals in the State received approximately \$41.7 million in insurance company rebates. Up to 294,000 children in Colorado with preexisting health conditions can no longer be denied coverage by insurers.

So even if you disagree with the law, it is important to note that the ACA is helping our constituents. I hope we can end these relentless attacks and we can help more constituents obtain coverage under the law.

We should look at the example for Medicare Part D. I can attest to it, because I was here. Many Democrats, including me, did not vote for the law and had real concerns about how it was implemented. But we still had town hall meetings and other events so that our seniors got coverage that cut their drug costs. I hope we can work, as we look into the next year, in a bipartisan way to make the ACA even better, instead of trying to find ways to undermine and repeal it.

Now, I appreciate the witnesses coming today. I know GAO has some important insights into CMS contracting for Healthcare.gov. And anything we can do to improve that contracting is good for me. I hope CMS has learned from the Web site's flawed launch. And I want to know the plan to make sure they do better moving forward.

And I want to welcome you, Mr. Slavitt. You are new to CMS. You will have primary responsibility for the Web site. So I hope you can tell us what you plan to do in 2015.

Thank you, Mr. Chairman.

Mr. MURPHY. The gentlelady's time has expired. I now recognize Dr. Burgess for 5 minutes.

<sup>1</sup>The fact sheets have been retained in committee files and also are available at <http://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=102587>.

**OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A  
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BURGESS. I thank the chairman for the recognition, thank Mr. Slavitt for joining us here again at our subcommittee.

You know, throughout the development and the rollout of Healthcare.gov, this subcommittee had repeated assurances that the systems were and would be ready to go, and that the implantation was on track. At a hearing in September, literally days before the October 1 launch of Healthcare.gov, we had repeated assurances from the then director of the Center for Consumer Information and Insurance Oversight, Mr. Gary Cohen. He said unambiguously that on October 1, Americans would be able to go online, would be able to see premium net of subsidy, and would be able to sign up. We all know now that those assertions were fact-challenged.

The Center for Medicare and Medicaid Services undertook this mammoth project without effectively planning for its development or its oversight. This has led to hundreds of millions of taxpayer dollars being wasted. Again, Gary Cohen and other HHS officials told us time and again that the Web site was working. That was factually incorrect. It was not working. And it still may not be working, because the back-end systems, those systems that are responsible for actually paying providers, have not been built.

Consumers may believe the Web site is fixed because some of the frontend problems have been addresses. But there is no way to verify inaccuracies about things like citizenship and income level, or insure that the correct subsidies are being paid for insurance premiums.

Thanks to this investigation, we now have definitive proof that the Department of Health and Human Services was fully aware that these systems were not ready for prime time. Their own contracting documents show that they only expected 65 percent of the Federal exchange to be ready on October 1. And then, of course, we are continuously reminded that the promises made by the administration simply could not be kept because the groundwork had not been done and the Web site was not prepared. We are all still wondering what happened to the promised \$2,500 in premium savings that every family in America could look forward to. We are all wondering what happened to the ability for people to keep their doctors. We are all wondering what happened to the ability for people to be able to keep their insurance plan.

Now, Mr. Slavitt, Mr. Cohen also was asked at his last appearance here in January about the issue on the risk corridors and risk sharing. The question came up about what if there is not enough money in the risk corridor to actually cover the premium shortfalls that the insurance companies are experiencing. And would he look to—that was Mr. Cohen—would he look to supplementing those funds from general revenue of the Treasury of the United States. He couldn't answer the question. I asked him if he could provide us with a legal memorandum upon which he relied to obtain the ability to get funding from other sources if the internal funding was not enough to cover the cost of the risk corridors. That was January. I am still waiting. I would like to know if I am going to

receive an answer to that question. And if so, when that answer might be forthcoming.

The fact of the matter is, both the Department of Health and Human Services and the White House failed to heed internal and external warnings about the lack of readiness of the exchanges. Now, we have the General Accountability Office report. And it is astonishing to see that after all the money has been spent, not all of it wisely, the Agency continues to ignore recommendations and continues to pump money into what may be a futile effort.

We are well on track to sink over \$1 billion into the development of this Web site. We have very little to show for our money. I am eager for the testimony of the witnesses today. I thank the chairman for the recognition. I will yield back the time.

Mr. MURPHY. The gentleman yields back. I now recognize the ranking member of the full committee, Mr. Waxman, for 5 minutes.

**OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Mr. WAXMAN. Thank you very much, Mr. Chairman.

This is the twelfth hearing this committee has held on the Affordable Care Act since enrollment began in October 2013. These hearings, if you look at them, all have one purpose: to undermine the Affordable Care Act regardless of the facts. The hearings have misled the public and I think squandered taxpayers' dollars. In fact, the Affordable Care Act is a historic success. It has made comprehensive healthcare reform a reality for the American people. More than 8 million people have signed up for private health insurance plans through the Federal and State marketplaces, exceeding CBO's enrollment estimates by over a million people.

An additional 6.7 million individuals have enrolled in Medicaid or the CHIP program as of May of this year. Three million young adults under the age 26 have enrolled in their parent's health insurance plans. And the fact sheets the Democrats put out from our staff reveal that in my district alone, if I can be parochial, 17,000 residents who were previously uninsured now have quality affordable health coverage because of the Affordable Care Act.

So I am giving some perspective that the law has been a success. It is accomplishing what Congress and President Obama intended. Instead, we have another hearing of this committee, or another subcommittee of this full committee, trying to say how the Affordable Care Act has problems and did things wrong and presumably should lead us to the conclusion it should be repealed.

Well, in a lawsuit, there is a word called stipulate. We can stipulate to what the GAO has reported. And they have reported some things that for which we ought to be concerned. Because despite the success of the law, the initial rollout of Healthcare.gov had serious flaws. And I'm glad we are going to hear from GAO, the Government Accountability Office, on their investigation of Healthcare.gov contracting. We should always try to learn from mistakes, not dwell on them but learn from them. And I am glad that Mr. Slavitt is here to tell us what the administration has learned and what is being changed as a result.

I have had experience with flawed contracts. I was the chairman of the Oversight Committee. And we released a report that identified nearly 200 contracts worth over a trillion dollars that involved significant waste, fraud, abuse, or mismanagement. The FBI had a contract to create a virtual case file system that had to be cancelled after spending over \$100 million. The Department of Homeland Security's contract to build a high-tech border fence—that was supposed to keep out all these immigrants, and we are still having problems—that fence had to be canceled after wasting a billion dollars. The Coast Guard had a multibillion-dollar deep water contract to build boats that would not float.

My point is not to excuse the Healthcare.gov problems, but to put them in context. With the exception of Tom Davis, Congressional Republicans showed little interest in these enormous wastes of taxpayers' dollars when George W. Bush was President. I think we should care about waste, fraud, and abuse no matter who is President. And I am proud that Healthcare.gov was fixed quickly. Not as quickly as I would have liked, but fixed nevertheless and in time to help millions of Americans enroll for insurance coverage.

But I want to learn what went wrong so CMS can do a better job for the next time, not the way the Republicans handle this, see we told you so. There are problems, we told you there would be problems. OK. And then their conclusion is, repeal it so they can replace it. But they have never given us a replacement. Well, people are getting insurance who couldn't get it in the past because they had preexisting medical conditions. People are finding that their insurance can't be canceled on them after they have paid just because they got sick. Women are not discriminated against. People who couldn't afford it can now get insurance because we give them tax breaks in order to pay for it.

So I am eager to learn what the Agency is doing so enrollment in 2015 goes more smoothly. We have unequivocal proof that healthcare reform is a success. We now need to make the 2015 enrollment period as smooth as possible so we can build on the success. Let us go toward trying to make things better, not dwell on things that were wrong, especially if you learned the lessons and fixed the problems.

Mr. MURPHY. The gentleman's time has expired. Just a message to members and to our folks giving testimony today: We are expecting votes around 10:30, 11:00—10:25, 10:40, I should say. And so we are going to try to go through this. I will have a quick gavel and ask all members really to stick with their 5 minutes as we go through this, or I will really bang it hard. And then we will move forward. If we need to be interrupted by votes, we will come back right after votes to complete things.

So now I would like to introduce the witness on the first panel for today's hearing. Mr. Andy Slavitt is the Principal Deputy Administrator for the Centers for Medicare and Medicaid Services. In his new role, he will be responsible for agency wide policy and operational program coordination as part of a new management structure that comes in response to lessons learned from the rollout of Healthcare.gov and recommendations put forth to the secretary.

I will now swear in the witness. Are you aware that the committee is holding an investigative hearing, and when doing so has

the practice of taking testimony under oath? Do you have any objections to testify under oath?

Mr. SLAVITT. No, I don't.

Mr. MURPHY. And the Chair advises you that under the rules of the House and rules of the committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during today's testimony?

In that case, would you please rise, raise your right hand? I will swear you in.

[Witness sworn.]

Mr. MURPHY. Thank you. The witness answered the affirmative, so you are now under oath and subject to the penalties set forth in Title XVIII, Section 1001 of the United States Code. You may now give a 5-minute summary of your written statement, Mr. Slavitt.

**STATEMENT OF ANDREW SLAVITT, PRINCIPAL DEPUTY ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES**

Mr. SLAVITT. Good morning, Chairman Murphy, Ranking Member DeGette, and members of the subcommittee. I am Andy Slavitt, Principal Deputy Administrator of CMS.

I joined CMS 3 weeks ago from the private sector where I spent the last 20 years principally working with physicians, hospitals, health plans, and employers on solutions to problems of healthcare cost, quality, and access. In the private sector, I both started my own healthcare technology business and run larger scale health services organization with more than 30,000 employees.

In late October of last year, I began my involvement with the Affordable Care Act implementation when I joined a group of people helping the CMS team on the turnaround effort of the health insurance marketplace. I am very pleased to appear before you today. And before answering your questions, I will briefly walk you through some of the progress of the Affordable Care Act to date and talk about our priorities for the coming period.

There is growing evidence that suggests that the Affordable Care Act is making a difference in the lives of millions of Americans. In the first full year, millions of Americans selected a private insurance plan through the State or Federal health exchange marketplace, and millions more have retained coverage on their parents' policies or have qualified for Medicaid or CHIP.

In addition, we are seeing historically low growth in overall health spending, which has continued into 2014. This is good news for consumers with the typical premium paid for a policy purchased in the marketplace under \$100, and good news for taxpayers as the recent Medicare Trust Fund report shows. And, importantly, this success is not being achieved by Government policy alone, but in partnership with the private sector as insurers grow by competing to provide better access to quality affordable services.

Now, as we move into our second year of marketplace implementation, we must build on the progress that is underway and heed the lessons of the last year. Let me outline for you our highest priorities. First, we are focused on increasing the value consumers get when they come to the marketplace. This means continuing to im-

prove the information, plan options and affordability of the shopping experience.

Second, we have critical technical and operational priorities. We must continually add automation. That has begun with critical releases this summer and will continue this year and in following years. While the consumer facing Web site is of course live, we are adding functionality to allow consumers to easily renew their coverage. Whether on the consumer-facing side or the back end, our technology improvements will be more continuous and more incremental. We have a very strong sense of our critical path. Our software releases so far have been on time, and we are managing these deliverables daily.

Third, let me address our management priorities to improve execution. As part of the turnaround team, I experienced firsthand the challenges of the first year of marketplace implementation. And at CMS, I am now helping to oversee a series of changes to improve the management of the marketplace. As Secretary Burwell announced in June, we have created clear, top-down accountability. We have also improved the management end of, and communication with, our key contractor with better defined requirements, metrics driven contract reviews, and requirements for skinning the game. We have expanded our testing protocols and built more testing into the schedule.

Even as we address the major concerns from last year, new ones will emerge. And our management structure and team must surface and address issues in a disciplined manner, just as we did during the turnaround.

This coming year will be one of visible and continued improvement, but not perfection. We are in the early stages of a program newly serving millions of consumers and are still learning about the best ways to support their unique needs. And we are setting up and testing new processes and new technologies along the way.

From my experience at this stage, businesses begin to see how closely their design matches the battle tested needs of the market. Good organizations focus, prioritize, and learn and continuously improve their operations and the services they provide. It is not always easy, but we understand what we need to do and are making the right progress to have a successful open enrollment, and continue to deliver on the promise of the Affordable Care Act to improve healthcare access, cost and quality for all Americans.

Thanks, and I look forward to your questions.

[The prepared statement of Mr. Slavitt follows:]

STATEMENT OF

ANDREW SLAVITT

PRINCIPAL DEPUTY ADMINISTRATOR,  
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

A CHANGED APPROACH TO HEALTHCARE.GOV

BEFORE THE

U. S. HOUSE COMMITTEE ON ENERGY & COMMERCE  
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

JULY 31, 2014

**U.S. House Committee on Energy & Commerce,  
Subcommittee on Oversight & Investigations  
A Changed Approach to HealthCare.gov  
July 31, 2014**

Good morning, Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee. I'm Andy Slavitt, Principal Deputy Administrator of CMS. I joined CMS three weeks ago from the private sector, where I spent the last 20 years principally working with physicians, hospitals, health plans, and employers on solutions to problems of health care cost, quality, access and improving the patient experience. In the private sector, I have experience both starting my own health care technology business and operating larger-scale operations with more than 30,000 people. Until late October of last year, I had only peripheral involvement with the Affordable Care Act implementation, when I joined the CMS team as a contractor to help oversee the turnaround effort of the Health Insurance Marketplace.

While new to the Federal Government, I joined CMS to help oversee the implementation of the Affordable Care Act that is critical to delivering the promise of better affordability, better access and better quality to the American people. I am closely involved in working across the agency to provide the Center for Consumer Information and Insurance Oversight (CCIIO) and CMS entities the resources, capabilities and management needed to achieve a successful second year of operation.

As we plan for a second year of Open Enrollment, we are focused on building on the advances made for consumers during the first year. Our focus is on providing consumers more choices for coverage and affordable options, assisting them with selecting the options that are right for them, and educating first-time and newly insured consumers about their benefits, their eligibility requirements, and their financial protections.

At the same time we are keenly aware of the challenges of Year Two in a new program of this scale, particularly one that faced significant challenges in its first year. We are still working with brand new processes and technology, we are still establishing an understanding of unique consumer behavior and needs, and we are reacting to and solving new problems for the first time. It is thanks to the work of a very committed team of public servants and contractors and heeding

the lessons of the last year that we will continue to build on the success of the first year of state and Federally-facilitated Marketplaces.

**Affordable Care Act Implementation: Building on Progress in Affordability, Access and Quality**

Evidence confirms that the Affordable Care Act is working as intended, making a difference in the lives of millions of Americans. Health care is becoming more affordable, with greater access and assurance of continuous coverage, and with improvements to quality and choice.

In the first full year, Americans have taken to a new way to purchase health insurance, as millions of Americans have selected a private insurance plan through their state or Federally-facilitated Health Insurance Marketplace. Millions more have retained coverage on their parents' policies and have qualified for Medicaid or CHIP.

In addition, recent years have seen historically low growth in overall health spending, and a variety of recent data show that very slow growth in health care costs has continued into 2014.<sup>1,2</sup> Preventive benefits, including wellness visits for women and screenings with no cost sharing for Medicare beneficiaries, as well as new incentives to pay doctors and hospitals for improving outcomes, are aimed at improving the quality of the health care that Americans receive.

*Reductions in the Uninsured Rate*

With the initial Marketplace open enrollment period now over, several recent reports make clear that the Affordable Care Act is reducing the uninsured rate. A study published in the New England Journal of Medicine found that, as compared with the baseline trend, the non-elderly uninsured rate declined by 5.2 percentage points by the second quarter of 2014, a 26 percent relative decline from the 2012–2013 period corresponding to 10.3 million adults gaining

<sup>1</sup> Council of Economic Advisers. 2014. "Recent Trends in Health Care Costs, Their Impact on the Economy, and the Role of the Affordable Care Act." *Economic Report of the President*, [http://www.whitehouse.gov/sites/default/files/docs/erp\\_2014\\_references\\_0.pdf](http://www.whitehouse.gov/sites/default/files/docs/erp_2014_references_0.pdf).

<sup>2</sup> Jason Furman and Matthew Fiedler. "Alongside Expanded Coverage, Underlying Slow Growth in Health Costs Is Continuing," <http://www.whitehouse.gov/blog/2014/05/27/alongside-expanded-coverage-underlying-slow-growth-health-costs-continuing>.

coverage.<sup>3</sup> Using the same underlying data, Gallup found that the adult uninsured rate in the United States fell to 13.4 percent in the second quarter of 2014, representing the lowest quarterly recorded average since the survey began tracking the uninsured rate. According to Gallup, more than half of the newly-insured got their new coverage through the Marketplace.<sup>4</sup> The Urban Institute's Health Reform Monitoring Survey found a 4.0 percentage-point drop in the uninsurance rate for non-elderly adults between September 2013 and June 2014. The drop corresponds to a 22.3 percent reduction in the uninsurance rate, or a net gain in coverage of approximately 8 million adults.<sup>5</sup> Similarly, a Commonwealth Fund survey found that following the Affordable Care Act's first open enrollment period, the uninsured rate for non-elderly adults declined from 20 percent in July to September, 2013 to 15 percent in April to June, 2014, or an estimated 9.5 million fewer uninsured adults.<sup>6,7</sup> These independent surveys all point to the same overarching trend—the success of the Affordable Care Act in lowering the number of uninsured Americans.

#### *Consumer Protections and Affordable Coverage*

The Affordable Care Act benefits Americans broadly, not simply those who are newly insured. Over the past three years, Americans have benefitted from insurance reforms that have already gone into effect, such as allowing adult children up to age 26 to stay on their parents' insurance, eliminating lifetime dollar limits on essential health benefits, and prohibiting rescissions of insurance when someone gets sick.

Now, in 2014, pre-existing conditions no longer preclude individuals from gaining health insurance, and consumers have better access to comprehensive, affordable coverage. New

<sup>3</sup> New England Journal of Medicine, Health Reform and Changes in Health Insurance Coverage in 2014.

<sup>4</sup> After Exchanges Close, 5% of Americans Are Newly Insured, <http://www.gallup.com/poll/171863/exchanges-close-americans-newly-insured.aspx>

<sup>5</sup> Urban Institute Health Policy Center: Health Reform Monitoring Survey: Quicktake: Number of Uninsured Adults Continues to Fall under the ACA: Down by 8.0 Million in June 2014, <http://hrms.urban.org/quicktakes/Number-of-Uninsured-Adults-Continues-to-Fall.html>

<sup>6</sup> The Commonwealth Fund: Tracking Trends in Health System Performance: Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period, July 2014, [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/jul/1760\\_collins\\_gaining\\_ground\\_tracking\\_survey.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/jul/1760_collins_gaining_ground_tracking_survey.pdf)

<sup>7</sup> After Exchanges Close, 5% of Americans Are Newly Insured, <http://www.gallup.com/poll/171863/exchanges-close-americans-newly-insured.aspx>

protections also ensure that consumers' premium dollars are spent primarily on medical care, rather than on administrative expenses. Since the program's inception in 2011, this protection has saved consumers an estimated \$9 billion.<sup>8</sup> And consumers now have the comfort of knowing that if their employment changes or they lose coverage for any reason, they can purchase affordable coverage through the Marketplace—regardless of their personal health history.

#### *Benefits Felt Across the Health Care System*

These market reforms are effective because they have benefits across the health care system. Reductions in the uninsured rate should mean doctors and hospitals provide less uncompensated care, a cost that is often passed along to taxpayers as well as consumers and employers who pay premiums for health coverage. And new pools of people buying insurance means insurers have an opportunity to grow by competing to provide better access to quality, affordable choices, the benefits that consumers are used to in any competitive marketplace. The creation of a successful, viable health insurance market had benefits for all Americans no matter where they get their health insurance.

#### **Affordable Care Act Implementation: Building on Progress and Lessons From Year One**

Our focus now is on several critical priorities to build on the progress from our first year of operations. First, we are focused on increasing the value to consumers by continuing to improve the information, plan options, and affordability of the shopping experience. Second, we need to continue to automate the back end systems of the Marketplace. Third, we are addressing the execution and technology lessons we learned during the first open enrollment period with a more disciplined, highly accountable and visible management structure.

#### *Bringing More Value to Consumers in the Marketplace*

Like any marketplace, the Health Insurance Marketplace leverages technology to bring more value, better information and a better shopping experience to consumers. Driven by competition and the significant demand for health coverage, our goal is to expand health plan options with more affordable premiums for consumers.

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<sup>8</sup> [http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-MLR-Report\\_07-22-2014.pdf](http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-MLR-Report_07-22-2014.pdf)

Based on their experience in Year One, we are aiming for insurers to bring more options in more geographic markets, including in markets where consumers had limited options for coverage.

While we are still reviewing the proposed plans to ensure they meet the requirements for participation in the Marketplace, we have seen an increase over last year in the number of applications from issuers for the 2015 plan year. With more choices in year two, consumers should have an even greater opportunity to find a quality health plan that best meets their needs.

Enhanced competition among insurers means that in year two, insurers will continue to compete on the basis of plan quality and value, as consumers are no longer charged different premiums because of health status or gender. Advance payments of the premium tax credits are significantly lowering many consumers' premiums for insurance coverage through the Marketplace, with seven in ten consumers paying \$100 or less after tax credits.<sup>9</sup>

CMS is also bringing more value to consumers in the coming year by ensuring better transparency for provider networks. We are doing so in two ways. First, CMS will hold insurers to a "reasonable access" standard for network adequacy and will identify provider networks that fail to provide access without unreasonable delay, especially in areas that have historically raised network adequacy concerns, such as hospital systems, mental health providers, oncology providers, and primary care.

Second, CMS is continuing to monitor and improve consumers' access to provider directories to help consumers more easily find network providers. Insurers must now provide links that connect consumers directly to provider directories specific to a given plan option without needing to log in, enter a policy number, or navigate through various websites. CMS expects that these directories will be kept up to date and will include location, contact information, specialty, medical group, institutional affiliations, and whether the provider is accepting new patients—information consumers need to make informed health plan decisions.

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<sup>9</sup> ASPE Research Brief: Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014, <http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf>

CMS also plans to make the process of renewing coverage as simple as possible. We will encourage everyone to come back to the Marketplace to shop for the best coverage option that meets their needs and to update their eligibility information. But for those consumers who are satisfied with their current plan and don't want to change, we will follow the model used at most employers and in the Medicare Advantage and Part D programs, and allow people to automatically re-enroll in the same plan for the following year without doing anything.

*Adding Critical Functionality to Operate the Marketplace*

There are significant new technological requirements to support the operation of the Marketplace in a more automated fashion and to allow consumers to renew their coverage as seamlessly as possible in a Year Two. Doing this successfully means ruthlessly prioritizing efforts to execute on critical capabilities, while setting the course for further improvement and development of new functionality in coming years. This level of discipline is vital in both the private and public sector in executing projects of this magnitude.

Critical focal areas include completing functionality that was targeted for the first year of development, but has not yet been completed, such as more automated back end functionality, case management tools to assist consumers with more complex eligibility situations, and launching an online exchange for small businesses and their employees. In addition, we are building the functionality required for renewing members and adding to the infrastructure to better support a shorter open enrollment period. We are also making a few key consumer improvements, including a streamlined application process for the majority of new consumers. And we will remain committed to ensuring that the Marketplace continues to adhere to the stringent privacy and security protocols necessary to protect consumers' personally identifiable information. Importantly, we are focused on managing our resources efficiently and are conscious of the limited time available for technology development this year. Given the large amount of required development, we are focused on executing on our priorities in a disciplined way and adding additional functionality in years to come.

*Addressing Execution and Technology Lessons Learned from Year One Open Enrollment*

As part of the turnaround team, I experienced first-hand the challenges of the first year and at CMS, am helping to oversee a series of changes to improve the management of the Marketplace. We are building on our experiences of what worked during the first year of open enrollment. This year, we are making several critical changes to oversee the implementation of the Marketplace that align with best practices from the private sector.

First and foremost is the alignment of clear accountability for the leadership of the project. In June, Secretary Burwell announced a series of organizational changes designed to strengthen the implementation of the Affordable Care Act. The changes include the creation of two new roles to provide clear accountability and visibility for managing and delivering the technology necessary to strengthen implementation of the Marketplace. Those roles, with full support from me, the Administrator, and the Secretary, are designed to bring clear leadership, accountability and visibility into the delivery of this large and complex technology project.

This new leadership structure will improve the discipline and focus of the project, enhance communications, and identify risks throughout the project. Like any project of this size, there will always be ongoing challenges, but we are building an operation better suited to identify and resolve them. We will ensure that team members, regardless of their affiliation with CMS or with a private-sector contractor, are encouraged to bring attention to problems they encounter. From the top of the team to the bottom, our priority is on visibility into—and frank communication about—our daily progress.

This coming year will be one of continued improvement, but not perfection. We still have a lot to learn that will help us continue to improve the Marketplace. We are in the first year of a program newly serving millions of consumers, many with unique and complex needs and many of whom are gaining coverage for the first time. We are still learning about the best ways to support those needs and are setting up and testing new processes and new technologies along the way. From my experience, at this stage, businesses begin to see how closely their design matches the battle-tested needs of the market. Good organizations learn and adapt and continuously improve their operations and the services they provide. We are accountable to the American public for

delivering the best possible value as we implement the Affordable Care Act and will continue to monitor our progress and improve to fulfill this responsibility.

**Conclusion**

CMS takes seriously its commitment to the American people—to provide each eligible consumer access to quality, affordable health coverage through private insurance, Medicaid, or CHIP.

While the Marketplace is still at an early stage, we are hard at work building on the successes and lessons learned from the first open enrollment, and look forward to meeting the needs of consumers and insurers as we continue to learn and improve for future years. The transition to a reformed health insurance market will take sustained effort, persistence, and focus from all stakeholders, but CMS is committed to continuing to deliver on the promise of the Affordable Care Act and improving health care access, cost, and quality for all Americans.

Mr. MURPHY. Thank you. I appreciate your comments and appreciate your candor here before, because my very first job when I was a young man was mucking out horse stalls. And I felt like the difference between—but what I got to do was I got to ride the horses. So it was a nice reward. The difference between that job and this job is I don't get to ride the horses anymore. So I appreciate your honesty and candor in this. And I want to ask you some questions on those lines. You may recall that a year ago, Congress was told repeatedly the Healthcare.gov Web site was fine, it was ready. The months, days and weeks leading up to it, everything was ready to go. And the President said it would mirror the public's experience with other Web sites. So we have to ask, will Healthcare.gov be fully ready this fall?

Mr. SLAVITT. Thank you, Chairman. So I obviously wasn't here last year. It does sound like, certainly from the GAO report that I have seen, that a couple of things happened. First, the technology build was certainly bigger and more complicated than people expected. And I think the scope expanded because of that. And, secondly, as the GAO pointed out, there were some significant issues with the management of the project.

Mr. MURPHY. But for the future? Because you said it wouldn't be perfection. So are there going to be hiccups this fall, too?

Mr. SLAVITT. I am sorry?

Mr. MURPHY. Are there going to be some hiccups in the Web site implementation this fall?

Mr. SLAVITT. I think this year, we are in a vastly different situation. For one, we have a Web site that is already up and live and running.

Mr. MURPHY. Yes.

Mr. SLAVITT. We are adding continued improvements. And we are adding them in a much less risky fashion. We are doing releases frequently over the course of the summer, putting things live into production. We have built in a big testing window. So, you know, everybody will remain on their toes and nervous. Everybody knows what they need to do.

Mr. MURPHY. But I—

Mr. SLAVITT. But we are expecting to have a good open enrollment.

Mr. MURPHY. But the GAO said there were still significant risks for the next open enrollment period. So you are saying everything is going to be fine and ready?

Mr. SLAVITT. I think our job is to manage those risks, understand those risks, surface them and—

Mr. MURPHY. I don't want to take out my shovel. I just want to know—because if there is going to be problems, I would much rather you just tell the committee, "Look, we anticipate these problems, here is the actions we are taking to move forward." I think the whole committee would appreciate that so we don't have to get caught up in this guess game.

Mr. SLAVITT. Yes. Sure. Well, I expect that it won't be perfect with serving millions of people.

Mr. MURPHY. OK.

Mr. SLAVITT. There are certainly difficult situations. People are—many of them are enrolling in insurance for the first time. It is a

bumpy process at times. I think we have got a committed team of people though that by and large are doing a very good job, but there will clearly be bumps.

Mr. MURPHY. Any anticipation how many more people you will be enrolling in the fall, or how many will be enrolling for the first time?

Mr. SLAVITT. I don't know that.

Mr. MURPHY. Do you know in terms of your review of this, so far of those who have enrolled how many of those have enrolled for the first time?

Mr. SLAVITT. I have only seen the media reports, which I can't pull a number. But it was, I think, far greater than a half. But I have only seen that in the media.

Mr. MURPHY. When Secretary Sebelius was here before, I asked her a series of questions. I will repeat those to you. But I asked her how many were new. How many were people who previously had insurance and got a pink slip and was discontinued. How many were people who were newly eligible because of Medicaid. And of all those who signed up, how many were paying the same, less, or more.

Mr. SLAVITT. Um-hum.

Mr. MURPHY. And she said really the Web site has no way—there is no way of knowing any of those things. Would you agree that is true?

Mr. SLAVITT. Yes. I think that data is not yet known by us. I think we are getting a bead on what premiums people are paying. So that is good. We have a sense that there is good affordability offered to—

Mr. MURPHY. But when we see these numbers on how many people signed up—10 million, 11 million, whatever it is—compared to the 45 million for which there was a need for health insurance, we really still don't know how many of that original 40, 45 million are served new by this.

Mr. SLAVITT. So the Administrator has a chart in her office, which she calls her prettiest picture, and it is a graph of the uninsured rate over time. And it shows a drop to 13 percent—

Mr. MURPHY. So is that specifically reviewed by your office or by HHS to specifically look at people who are uninsured before and now are insured? Because you just told me that you can't really determine that, and Secretary Sebelius told me there was no way of knowing that.

Mr. SLAVITT. Yes. There is no way to determine that from the Web site.

Mr. MURPHY. OK.

Mr. SLAVITT. We do know the uninsured rate from the recent Gallup Report is down to 13 percent.

Mr. MURPHY. Have you tried to sign up for one of the plans on the Web site?

Mr. SLAVITT. I have—now that I am a Federal employee, I am in the FEHBP Blue Cross plan.

Mr. MURPHY. So you don't have to be in the Affordable Care Act yourself?

Mr. SLAVITT. I am a Federal employee.

Mr. MURPHY. Yes, well OK. And I am just curious, have you also reviewed with people if they have tried to access their physicians? The plan allows an initial visit and some other preventative care—not as much preventative care as I would like. But have you surveyed persons to find out if they have been able to see their physicians for follow-up appointments, their costs for example—to review their costs, their payment levels, their copay, their deductibles, have you reviewed any of those things? And—

Mr. SLAVITT. I will have to get back to you on that. I don't think we have any hard data, but I can certainly look and try to follow-up.

Mr. MURPHY. Thank you. I will keep track of time here. And, Ms. DeGette, you are recognized for 5 minutes.

Ms. DEGETTE. Thank you, Mr. Chairman.

So I agree that it is important to make the Federal exchange Web site, and also the States, work as well for people. And I am sure, Mr. Slavitt, you agree with that too, don't you?

Mr. SLAVITT. Yes, I do.

Ms. DEGETTE. And we want to make it as easy as we can for people to enroll. And especially as we reenroll in the 2015 plans, is that correct?

Mr. SLAVITT. That is correct, Congresswoman.

Ms. DEGETTE. Now—up till now, even despite the admitted problems with the Web site, 8 million people enrolled in the marketplaces, is that correct?

Mr. SLAVITT. Correct.

Ms. DEGETTE. And about 6.7 million enrolled in the Medicaid expansion, is that right?

Mr. SLAVITT. That is right.

Ms. DEGETTE. So, obviously, people were able to utilize those Web sites to get health insurance, is that right?

Mr. SLAVITT. That is correct.

Ms. DEGETTE. Now, I was looking at the part of the GAO report, and the GAO made five recommendations in the report. Are you aware of that?

Mr. SLAVITT. Yes, I am.

Ms. DEGETTE. And what is your opinion of those recommendations?

Mr. SLAVITT. We agree with most of those recommendations.

Ms. DEGETTE. Which ones done you agree with?

Mr. SLAVITT. I think the only thing in the GAO report that I think needs a little further clarification—it is not that I don't necessarily agree with it, it is the characterization of the Accenture contract. And I think it was characterized as ballooning in cost when in fact I think the Accenture contract was—there was an initial contract before the work was completely scoped—

Ms. DEGETTE. OK. Let me stop you, because that was one of their findings. But that wasn't one of their recommendations.

Mr. SLAVITT. Correct.

Ms. DEGETTE. Their recommendations—

Mr. SLAVITT. So I agree with all their recommendations.

Ms. DEGETTE. You agree with all five of their recommendations. And what steps are you taking to implement those recommendations?

Mr. SLAVITT. So we are doing a number of things. First of all, in the contracting front, it is very clear now who can give work to Accenture, how work gets approved, how that contract gets managed and, frankly, importantly, Accenture has skin in the game to make sure that they deliver. Again, I wasn't here last year, so I can't speak precisely to how the project was managed. But I can tell you that, now, there is daily intensive management of the project. The risks and issues and concerns are also surfaced and dealt with. We have built early warning indicators, and there is an accountability difference that I think is very significant.

Ms. DEGETTE. Are you looking at the interoperability issues as well? That was one of the problems we had before.

Mr. SLAVITT. There are, as you point out, Congresswoman, many different pieces of this project in order to go well. And so the coordination and the systems integration is something that I think was missing last year. And it is in place this year.

Ms. DEGETTE. Now, are you doing anything that goes beyond the recommendations in this GAO report, Mr. Slavitt?

Mr. SLAVITT. Yes. Well, fortunately or unfortunately, the GAO report wasn't news to the people at CMS. I think the people at CMS, who worked awfully hard but lived through that nightmare, don't want to go through that again. So I think actions were underway well before seeing this report. And I think they fall into the categories that I have talked about: contracting reform, technical and managerial oversight, focused and disciplined project management.

Ms. DEGETTE. Now, we keep hearing about how expensive the cost overruns and everything else in setting up Healthcare.gov were. Just as an aside, Mr. Chairman, I would like to know how much this lawsuit against the President is going to cost. But be that as it may, Mr. Slavitt, I want to ask you do you think we are going to be protected from cost overruns for the 2015 enrollment period?

Mr. SLAVITT. So again, I wasn't here last year. But the two things that went wrong last year, one of them actually was simply the inability for anybody, and quite reasonably so—and this happens in the private sector—to estimate how big this project is and how complex it is. We have got a better handle on that now. I don't expect those overruns.

Secondly, to the point of the GAO report, the contractor wasn't managed tightly with clear deliverables and requirements. That has been put to bed as well. So those two things are in much, much better shape.

Ms. DEGETTE. And were you aware—one last question. Were you aware that the uninsured rate in this country dropped 25 percent after the implementation of Healthcare.gov and the full implementation of the ACA?

Mr. SLAVITT. Yes. Yes, Congresswoman, that sounds right.

Ms. DEGETTE. Thank you. I will yield back, Mr. Chairman.

Mr. MURPHY. I will recognize Mr. Harper for 5 minutes.

Mr. HARPER. Thank you, Mr. Chairman. And thank you for being here today. And I have a couple of questions I would like to ask.

First of all, who is performing the role of systems integrator now? Who is doing that?

Mr. SLAVITT. Optum. The firm is Optum.

Mr. HARPER. OK. I am sorry.

Mr. SLAVITT. My prior company.

Mr. HARPER. And so who has that role now?

Mr. SLAVITT. Optum. The firm Optum does.

Mr. HARPER. OK.

Mr. SLAVITT. Plays that role.

Mr. HARPER. I got you. Yes. Some questions I would like to ask about some reports. Early this summer, we learned that there were nearly 4 million inconsistencies in the applications submitted via Healthcare.gov. Those inconsistencies are primarily for citizenship status or income. The failure to calculate these properly could mean that millions of Americans could have to pay back incorrectly calculated subsidies. So earlier this summer, it was reported that there were millions of these. First of all, how did this happen? And can't the Web site check for accuracy?

Mr. SLAVITT. Sure. So I appreciate the question. Inconsistencies occur because of the changes that occur in peoples' lives. And people end up having more current information than Government databases. So we ran last year, during open enrollment, hundreds of millions of checks against Government databases to check on income and citizenship status and so forth. And in some occasions where people particularly are in low-wage jobs, they are in seasonal work and other kinds of circumstances, their income is unpredictable. Or in other cases, they haven't file taxes before because they haven't made enough money. So what happens when that happens—and just to give you a perspective on this, for a typical family of four, there are 21 records searched through our automated process. If even one of those records turns up not to be a match because of income or some other thing, we have to pursue documentation. And we do indeed pursue documentation to try to ensure that these people are in fact telling the truth. And we have done that—

Mr. HARPER. How—

Mr. SLAVITT. I am sorry?

Mr. HARPER. How could a person on the form be a citizen or not be a citizen? Is that something that you can verify?

Mr. SLAVITT. There is documentation status. There is—whether it is a naturalization status and so forth. Those are sometimes not as current in the Government database as what the individual resident has in fact in their life.

Mr. HARPER. So, in an application—one application could have multiple inconsistencies, correct?

Mr. SLAVITT. That is correct.

Mr. HARPER. And do you have a number of how many Americans were affected by this problem?

Mr. SLAVITT. So I think there were a couple of million people who had inconsistent information that needed to be matched of some form or another. About—I would say roughly half of those are income changes. So these are people who will have to come back to the Web site—and we are urging people to do that—and make some adjustment, because it will spill out of course on their tax form. Of the other half, we have cleared, as of July 1, 425,000 inconsistencies. And greater than 90 percent of those are indeed in

favor of the individual consumer who had more up-to-date information than we did.

Mr. HARPER. You know, and this is obviously something we want to make sure doesn't continue. So what assurances can you give us today that we won't see these problems during the next enrollment period?

Mr. SLAVITT. Well, I think what we are learning is that a certain amount of these data discrepancy problems are going to be a fact of life.

Mr. HARPER. Yes.

Mr. SLAVITT. Because of the fact that we have people who do have variations—high variations in their income levels. And so that is going to occur in coming years. What is going to be different next year is we have now just released software that allows us to get at those inconsistencies much more quickly. What is important though is that people who we reach out to and we need additional documentation from, get in touch with us and get them back to us.

Mr. HARPER. Thank you, sir. And I will yield back.

Mr. MURPHY. Mr. Tonko for 5 minutes?

Mr. TONKO. Thank you, Mr. Chair. Mr. Slavitt, welcome.

And you earlier went through some national stats. And I have received information on my district who have been waiting to get info. And in the 20th Congressional District in New York, 11,000 residents who were previously uninsured now have quality, affordable health coverage because of the ACA. The number of uninsured residents in my district has declined by some 23 percent. 214,000 individuals in the district, including 137,000 women and 54,000 children now have health insurance that covers preventative services without any copays, coinsurance, or deductible. And 262,000 individuals in my district now have insurance that cannot place annual or lifetime limits on their coverage. And up to 37,000—37,000 children in my district with pre-existing conditions can no longer be denied coverage for health insurance purposes.

I think that is a tremendous bit of improvement. We obviously want to continue to grow those numbers. But it is comforting to know that that kind of success is coming the way of our district.

And so, Mr. Slavitt, part of the promise of creating the one-stop marketplaces was the ability to shop for health plans side-by-side and then apply in an apples to apples comparison. While the Federal Healthcare.gov site has done a good job in this regard in displaying the premiums and deductibles of various plans, it has been more difficult to assess differences in health plan networks or whether a particular doctor is in-network for a given plan. Could you tell us what CMS is doing to make it easier for consumers to access this information in advance of the upcoming open enrollment period?

Mr. SLAVITT. Thank you, Congressman. So you are indeed correct. And, in fact, in the last year, I believe the typical consumer had dozens—several dozens of options to choose from in health insurance. And our job is to try to continue to grow that. But as you point out, we have to make the information people are looking for more readily apparent and more easy to see. So we are asking the insurance companies this year to put direct links to the provider directory that fits the individual plan. But I would also just ask

consumers to do, and I would ask if you would talk to people in your district, is that those directories that the insurance companies keep, they are not always up to date. They try to keep them up to date. But it is always good to call the insurance company or to check with your—if there is a physician that you want to see to make sure that they are in the network, because this is really important information for people to choose from.

Mr. TONKO. OK. And in terms of allowing a consumer for example to search only for plans in which their doctor is covered, could—

Mr. SLAVITT. We don't have that ability. That is the kind of thing that might come in future years.

Mr. TONKO. What kind of obstacles stand in the way of that happening?

Mr. SLAVITT. You know, I think one of the lessons learned from this project is to take disciplined incremental steps to making progress, not trying to do too much. And, you know, our schedule is pretty much filled with things that are important to make sure we are executing well. And I think those are the kinds of innovations that I could really see us getting excited about adding in future years. But it didn't make the cut this year.

Mr. TONKO. Um-hum. And if I could just ask you a quick question about the Medicare Trust Fund? The trustee's report, as you know, came out on Monday. And they are talking about the fund being secure through 2030. That is 13 years longer than was projected in 2009 when the ACA was passed. The report noted that these changes may be due to the cost saving provisions of the ACA. Do you believe that to be correct?

Mr. SLAVITT. Well, I am not going to hold myself out as an expert, but it sounds logical.

Mr. TONKO. And in fact, since passage of the ACA, the Medicare costs have grown at or near record lows, is that not correct?

Mr. SLAVITT. That is correct.

Mr. TONKO. So would you anticipate any continuing or additional benefits coming via Medicare?

Mr. SLAVITT. Yes, I would.

Mr. TONKO. OK. Well, we appreciate the leadership that you have born with the ACA. And we thank you for the improvements. And I know on behalf of the district that I represent, the numbers are very encouraging. I share them with you here this morning, and we are going to continue to work to further improve so that one of these fundamental rights, the affordable and accessible quality healthcare for all, is continued. So—and strengthened.

So with that, I yield back. And thank you, Mr. Chair.

Mr. MURPHY. The gentleman's time has expired. Now, I recognize Mr. Griffith for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman. I do appreciate that. Mr. Slavitt, thank you for being here this morning.

You have indicated and testified that you were previously employed by Optum/QSSI, is that correct?

Mr. SLAVITT. That is correct.

Mr. GRIFFITH. And I think I heard you say in your opening statement that you left their employee approximately three weeks ago, is that also correct?

Mr. SLAVITT. A little longer than that. Yes, that is correct.

Mr. GRIFFITH. A little longer, how long?

Mr. SLAVITT. I could get you the exact date.

Mr. GRIFFITH. Well, I don't need the exact date. Four—between 3 and 4 weeks?

Mr. SLAVITT. Yes, yes, yes. You are—something in that nature.

Mr. GRIFFITH. OK.

Mr. SLAVITT. Yes.

Mr. GRIFFITH. Here is the question. You now work for CMS.

Mr. SLAVITT. Um-hum.

Mr. GRIFFITH. And from what I understand, you are a very talented individual. And that is a good thing for CMS. But if I understood your testimony as well, you have indicated that your previous employer is managing the Web site as the systems integrator, is that correct?

Mr. SLAVITT. Um-hum. That is correct.

Mr. GRIFFITH. OK. So then the natural question, as an oversight committee is, how are you able to manage your former employer? And doesn't this create a conflict of interest?

Mr. SLAVITT. Sure. Thank you for the question. So, Congressman, there is, as you know, an ethics pledge that I signed. And along with that, disposed of all of my stock basically that I had had in the company.

Mr. GRIFFITH. I—

Mr. SLAVITT. It is completely clear. I recused myself.

Mr. GRIFFITH. You disposed of all of your stock? You said basically.

Mr. SLAVITT. Yes, all of—yes.

Mr. GRIFFITH. OK.

Mr. SLAVITT. I am—yes, I am not trying to qualify that.

Mr. GRIFFITH. I didn't think you were, but I wanted to make sure on the record that you are saying you got rid of all of your stocks.

Mr. SLAVITT. OK. Thank you. Yes, I got rid of all my stock and any other ties, as appropriate. I have signed—and I am not qualifying with as appropriate—as was appropriate. So now as a public servant, I have a very clear set of rules to follow. I have this ethics pledge. And then within that ethics pledge, I have a limited waiver which allows me, for the purposes of health reform implementation only on the Web site, to be able to interact with all of the contractors, including Optum, as it solely benefits the implementation of the project. And so I do that and exercise that very carefully and very prudently. But that is a publicly available waiver that I can make sure to get to you, if you would like.

Mr. GRIFFITH. If you would, that would be great.

Mr. SLAVITT. OK.

Mr. GRIFFITH. And then I would like to talk about that waiver process. Because normally, in my experience, when you move from the private sector into the public sector, there is usually some kind of a period of not dealing with your former employer. That is usually a year or more. And if you could explain that process, how they came to this? And you said it was a limited waiver. We can certainly look at that later. But if you could explain that process, I'd appreciate it.

Mr. SLAVITT. Yes. So it is I think a 15-page document, which is—and I can get you the details. But—

Mr. GRIFFITH. I would appreciate that.

Mr. SLAVITT. But it is a—2 years is the waiver. And I think the only exception—I am sorry, 2 years is the agreement not to communicate with my old employer. And then there is this narrow exception for interaction relative to this implementation process.

Mr. GRIFFITH. All right. And I appreciate that. Let me ask you some questions about your former employer, because Optum/QSSI is a subdivision or is a subsidiary of UnitedHealth Group, isn't that correct?

Mr. SLAVITT. That is correct.

Mr. GRIFFITH. And in their 4/17 quarter 1 of this year earnings call, the UnitedHealth Group President and CEO, Steven J. Helmsley, recognized employees and said that, you know, we try to move our employees around in different divisions of the company. And so I am a little concerned about how much of a firewall is built between Optum/QSSI and UnitedHealth Group, because UnitedHealth Group is participating in some of the exchanges and in the Federal exchange. And so we have a situation where again there is an appearance of a conflict or inpropriety because if you are shifting folks around, I said to one of my staffers this morning, what do they have a machine like they did on Men in Black and they zap their memories and they remember nothing that they saw? Because it would appear that the folks at QSSI who then report to UnitedHealth Group—and, in fact, Larry Renfrow is—has an office—a title or a hat in both companies. And if that is the case, aren't they able then to gain information on competitors by participating in the process and in all these meetings, and then get an advantage over their competitors in the healthcare Web sites?

Mr. SLAVITT. So let me clarify two things.

Mr. GRIFFITH. OK. Please.

Mr. SLAVITT. First, nobody on the Healthcare.gov project is permitted to go back and to go outside of the project and transfer into United Healthcare. That is expressly prohibited. Secondly, just an important clarification, because it is a little bit confusing: United Healthcare and UnitedHealth Group are two different things. So UnitedHealth Group is a parent company that has two divisions.

Mr. GRIFFITH. Right.

Mr. SLAVITT. One is called Optum. One is United Healthcare. And so I don't want anybody to have the impression that Optum is a part of this insurance company. It is actually a sister company, a separately run entity—

Mr. GRIFFITH. Well, but it is a wholly un-subsidiary, is it—

Mr. SLAVITT. Correct. Correct.

Mr. GRIFFITH. OK. All right.

Mr. MURPHY. The gentleman's time has expired.

Mr. GRIFFITH. Thank you. I will have some follow-up questions and will present for answers after the meeting. OK. Thank you.

Mr. MURPHY. Thank you. I now recognize Ms. Castor for 5 minutes.

Ms. CASTOR. Thank you, Mr. Chairman. Good morning.

Throughout the country, everyone is seeing the benefits of the Affordable Care Act. And as of today, Americans who are interested

can access new fact sheets that provide statistics based upon each congressional district. So I encourage you to go to the Democratic Web site of the Energy and Commerce Committee and—or call your member, and we can provide those.

Now, I want to share some facts about the benefits of the law in my Florida district in the Tampa Bay area. There are over 24,000 individuals in my district who were previously uninsured but now have quality, affordable health coverage because of the Affordable Care Act. The number of uninsured in my district has declined by 15 percent. Now, that could have been higher if the Republican controlled legislature and our Governor would have expanded Medicaid in Florida. In fact, almost a million additional residents, Floridians, could have health insurance. That is 43,000 of my neighbors in the Tampa Bay area who could have been covered, but they remain uninsured because Florida refused to expand Medicaid. But over 40,000 people in my district were able to purchase coverage through the new health insurance marketplace, and nearly 10,000 young adults were able to retain coverage through their parent's plans. 43,000 of my older neighbors received Medicare Part D prescription drug discounts worth \$8.2 million. I mean, that is a great shot in the arm and terrific money back into their pockets.

So as we plan for the second year of open enrollment, we all want to make sure that we don't have the computer problems that we had last go around. So I want to ask you some questions about premiums, especially for the 2015 period. Now, open enrollment begins in November, is that correct?

Mr. SLAVITT. Correct.

Ms. CASTOR. November—

Mr. SLAVITT. 15.

Ms. CASTOR. 15.

Mr. SLAVITT. Yes.

Ms. CASTOR. So folks need to at some point—when will the Web site be ready to compare plans?

Mr. SLAVITT. So we are going to be sending out notices to people starting in October to come back to the Web site, update their information and letting them know that on November 15, they will be able to either, if they choose, come back to the Web site, shop for a plan, compare premiums and choose the plan they want, or as happens with Medicare Part D, Medicare Advantage, and most employers, if they choose to do nothing, they will be able to automatically reenroll if their existing plan is offered.

Ms. CASTOR. OK. And the deadline is in February—

Mr. SLAVITT. February 15.

Ms. CASTOR. February 15 of 2015.

Mr. SLAVITT. 2015.

Ms. CASTOR. Now, Republicans have predicted that premiums would skyrocket for the next go around, increasing by as much as 50 percent. But we can now test those numbers because the new rates are rolling out across the country. Are there any signs of the out-of-control rate increases that the Republicans have predicted?

Mr. SLAVITT. So far, the rate increases that have been publicly available from Rhode Island, Washington, and Delaware have all been in the mid-single digits. California, I believe, is going to come out with their numbers today. So I think that will be closely

watched, because of the size of the State. Colorado's, I believe, have been very steady by and large. So while this isn't going to be true for every single individual in every single county in America, by and large the early results look positive—very positive.

Ms. CASTOR. Great. And is it accurate to say that there are more choices in the marketplace this go around, or will it depend upon the State?

Mr. SLAVITT. There will be more choices this year than last year.

Ms. CASTOR. So what does competition tend to do when you have—when consumers have more choices?

Mr. SLAVITT. Better prices, better value, better services.

Ms. CASTOR. Does that mean that if you have greater competition that puts pressure on the insurance companies to keep their premiums low?

Mr. SLAVITT. I think this is one of those win-win situations where the private sector can grow by actually providing more value to consumers. And that appears to be what is happening.

Ms. CASTOR. And what else helps keep premiums low under the Affordable Care Act?

Mr. SLAVITT. Well, certainly, the preventive visits do. The ability for people to qualify for tax credits. You know, I think there is a whole host of things that—

Ms. CASTOR. You know, one of my favorite ones—what we did in the Affordable Care Act is the 80/20 rule, the medical loss ratio that says when a consumer purchases a policy, they have to get something meaningful. And insurance companies can't spend too much on profits and administrative costs. And when they do, they have to rebate the money back to consumers. And for my—because I represent the State of Florida, we are really happy that our consumers are going to receive \$42 million back this summer. I have already heard from many of our—my neighbors. And sometimes those rebates go back to the employer. So you do need to keep an eye, isn't that right?

Mr. SLAVITT. Yes. In fact, the numbers that I have seen are that something like \$9 billion has been returned to and saved by consumers in that process.

Ms. CASTOR. That has been very important in this day and age. Thank you very much.

Mr. MURPHY. The gentlelady's time has expired. I now recognize Mr. Johnson for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman. Mr. Slavitt, it is good to see you today. You and I have had chances to interact before, and I appreciate you being with us. I agree with Mr. Griffith, based on your background, it looks like CMS is going to be the beneficiary of your experience and background.

Mr. SLAVITT. Thank you.

Mr. JOHNSON. You have talked about your many years in the private sector. Could you give a very quick summary of your years of experience and expertise and what it primarily focused on?

Mr. SLAVITT. Sure. So I started my own health information technology company back in the '90s. It was a small business that ended up serving consumers. I ended up selling that business. I worked with Optum for a number of years. I oversaw the health information technology business and grew that. I worked very

closely on building lots of industry wide capabilities around things like revenue cycle management, population health management. I worked closely with hospitals, with physician groups, with health insurance plans, State Governments, all really focused on quality, cost and access issues.

Mr. JOHNSON. OK. And to summarize, I think when you were responding to Mr. Griffith's questions, you led the team that basically made Healthcare.gov usable in October, correct?

Mr. SLAVITT. That is correct.

Mr. JOHNSON. OK. So I want to ask you, you have all of those years of experience and expertise in information technology, specifically in the healthcare arena. How much should Healthcare.gov have cost?

Mr. SLAVITT. That is a really good question, and I am not sure I know the answer to it. It is not unusual for large-scale health projects—for example, I can think of big projects from Kaiser Permanente when they installed electronic medical records—to cost a couple billion dollars to put in place. It is hard to know what the benchmark is to build a consumer facing Web site and set of back-end systems to connect to 50 States, to Medicaid plans, to insurance companies. So I am not quite sure.

Mr. JOHNSON. Well, let me help you a little bit. Because I don't know if you remember or not, but my background is a 30-year information technology professional.

Mr. SLAVITT. Yes. I do.

Mr. JOHNSON. So I have been through the lessons learned and the trial by error of trying to project costs of complex IT systems like this. The GAO says that we spent nearly a billion dollars on this, with the cost climbing. Do you believe that taxpayers have received a good return on their investment thus far?

Mr. SLAVITT. Congressman, I think two things happened. And it is hard to know how much fits into each category. The one thing that happened is, clearly, this was a more complex project and needed a lot more work than people expected. And for that part, I think—

Mr. JOHNSON. And that goes without—yes. And see, that goes back to the genesis of some of the questions that we got into the last time you and I were here. If you have a firm set of requirements, and if you have a systematic life cycle design process, it is much easier to project those costs.

Mr. SLAVITT. Right. Yes.

Mr. JOHNSON. I know when I was doing large-scale program management on large IT systems, the industry general rule was that in the life cycle of a complex system, that the implementation part—the design, the building, the implementation part is only about 25 percent of the cost—the life cycle cost of a system. The rest of the cost is in maintenance, operations and further on down the road. So if this thing has already cost the taxpayers a billion dollars or more to get to where we are today, we can reasonably expect that this is going to cost billions, billions more over the life cycle of this thing, correct?

Mr. SLAVITT. Yes, I couldn't put an estimate on that.

Mr. JOHNSON. But you do agree with the concept in general that maintenance and operation costs a heck of a lot more overtime than the initial implementation does, right?

Mr. SLAVITT. I do think there will be an ongoing operating cost. I don't know that it will be greater. I think that I have to look, and I would have to look at the budget request, which I don't have with me.

Mr. JOHNSON. OK. Well, the budget request has nothing to do with how much it is going to cost.

Mr. SLAVITT. To do——

Mr. JOHNSON. You understand how the industry works.

Mr. SLAVITT. Yes.

Mr. JOHNSON. You understand the life cycle of software development. You understand that. But I appreciate it that you don't really want to answer that question.

Mr. SLAVITT. I don't know the answer.

Mr. JOHNSON. The GAO says ultimately more money was spent to get less capability. Do you agree with that?

Mr. SLAVITT. I think there were clear inefficiencies——

Mr. JOHNSON. Because a lot of it is still not working.

Mr. SLAVITT. I think there were clear inefficiencies in how this was managed. I think, didn't it also say, Congressman, that in the real world, it is not always possible to know your scope going in. In an ideal world, you can. But I think the estimates proved that they need to do more work in the——

Mr. JOHNSON. Thank you, Mr. Chairman. And I agree that it is not always possible to know the scope, but it is possible to fence the scope and, therefore, knowing that what you are going to pay for is what you are going to get, which is clearly not what happened here.

Mr. MURPHY. Thank you. The gentleman's——

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. MURPHY. The gentleman's time has expired. I again remind members, please keep it in the timeframe, because we are expecting votes in a few minutes. And I want to be fair to everybody. Mr. Yarmuth, you are recognized for 5 minutes.

Mr. YARMUTH. Thank you very much, Mr. Chairman. Mr. Slavitt, thank you for your testimony and your work.

I want to talk about some of the things that have happened in Kentucky since we are actually doing an update, and I am very proud of the experience we have had so far in my State. But there was actually some pretty astounding news earlier this week regarding the trustees of Medicare coming from them about the prospects for viability of the Medicare trust fund. Are you familiar with that information?

Mr. SLAVITT. Yes, I am, Congressman.

Mr. YARMUTH. Could you tell us what has happened? Because, as I recall, when we passed the Affordable Care Act in 2010, at that time the trustees were projecting the trust fund would be insolvent by 2017.

Mr. SLAVITT. I believe, if I am not mistaken, that in summary the projection is the trust fund life expectancy was extended to 2030.

Mr. YARMUTH. 2030. So that is pretty astounding that in 4 years the projection extended the life—the viability of Medicare by 13 years. And there was also some really fascinating and I think impressive data about pro-beneficiary expenditures that they essentially were flat year to year, there is no increase when historically they have been running at somewhere between 5 and 10 percent annually, is that correct?

Mr. SLAVITT. That is correct.

Mr. YARMUTH. All right. Thank you. So one of the things that I know we have spent a lot of time talking about, people who have signed up for insurance in the private insurance market under the Affordable Care Act. But this is data that has come about from the Commissioner of Medicaid in Kentucky. And I think this is so impressive. If you look at the top map, that is the 120 counties of Kentucky, color coded by the percentage of uninsured citizens in those counties prior to the ACA.

[Chart.]

Mr. YARMUTH. And red and orange—which are most of the counties in Kentucky, I think all but probably a dozen—were rates of 17 to 20 percent, and then more than 20 percent. The bottom map is the current situation. And it is staggering to me because—the green is under 13, is under 11 percent, 8 to 11 percent, and blues, 5 to 8 percent, and the dark blue, less than 5 percent—we have counties in Appalachia, southeastern Kentucky, that went from having the highest uninsured rate in the State, over 20 percent, to the lowest uninsured rate, under 5 percent. And that to me is a staggering accomplishment. In Kentucky, we essentially have insured about half of the previously uninsured population of the Commonwealth, in a State that has very poor health historically and currently, and people who are in desperately in need of healthcare. And what is even more important, I think, than that is that the report of the commissioner of Medicaid in Kentucky talked about how preventive service utilization has increased dramatically to almost 16 percent. An annual dental visit, which they weren't doing before. Adult preventive services increased by almost 37 percent, breast cancer screening by 20 percent, colorectal cancer screening by—up by 16 percent. Very, very important health measures that I think will pay off for the Commonwealth economically but also for the life of these citizens going forward.

And also what is, I think, very important to note is how much reimbursements went up for providers in the Commonwealth, totals of—let us see. Reimbursements from now—those now covered under Medicaid expansion went up by \$284 million in just the first 6 months. So, many of those hospitals and doctors and other providers who were providing uncompensated care for Kentucky residents are now being compensated. And that also is a great benefit to the taxpayers and the treasury of the Commonwealth.

So I just mention those things because it is very clear to me that States that embrace the Affordable Care Act and are committed to making it work are having very, very positive experiences. The adverse experiences are coming in States where the administrations of those States, the governments decided in some cases just not to participate in, and other cases to try and sabotage the law.

So I thank you for your work and for the information you brought to us today. I yield back.

Mr. SLAVITT. Thank you.

Mr. MURPHY. The gentleman yields back. Dr. Gingrey, you are recognized for 5 minutes.

Mr. GINGREY. Mr. Slavitt, one of the members earlier asked or made the comment that because of the medical loss ratio—I think maybe they were talking about the State of Florida—how much money was returned to the consumer of health insurance through the plans. Let me start out by specifically asking you this, because this has also been reported: If an individual ended up receiving an incorrect subsidy that they were not entitled to, what will be done to rectify this issue? Specifically, will they be sent additional funding if the subsidy was too low? Or will they need to pay back the money if the subsidy was too high? And when will consumers know if they owe the Government more money?

Mr. SLAVITT. Yes. Thank you for the question, Congressman. So if individuals have changes in their income, the best advice is they should come back to the Web site and update that information so that their tax credit and premium can be updated. For those adjustments that are not made, when it comes to tax time, they will either receive a refund or they will have additional money that they will owe.

Mr. GINGREY. Well, I think we need to get some specific answers on questions like that, because this pay and chase model, as we know in past, absolutely in regard to let us say paying Medicare claims that were fraudulent, and then you have to go chase them down to try and get them back, you never do. You are aware of this GAO report that came out—well, I guess today. And it states that in January, CMS awarded a new company a contract to continue work on the Federal marketplace for \$91 million, right?

Mr. SLAVITT. Correct.

Mr. GINGREY. GAO says in the report that the cost now has ballooned to more than \$175 million, is that correct?

Mr. SLAVITT. That is what the report says, yes.

Mr. GINGREY. Yes. Right. And the investigation of course ended a few months ago. Do you know if the cost—this estimated cost of 91 million that is now 175 million that is in the report, has it gone up even further since the report?

Mr. SLAVITT. No. I think the estimate of the total contract—and again, this is not what has been paid, this is what is being budgeted—is about 170 million. That is correct.

Mr. GINGREY. You know, that is a pretty big error, 91 million versus 175 million—how is it you can offer a contract for \$91 million and have it grow that much over such a short period of time?

Mr. SLAVITT. So I think the proper characterization of that contract is that the scope of the contract was completed after the initial contract was awarded. So I wouldn't characterize the cost as ballooning. I would actually characterize it as the proper scope with the contractor, Accenture, was determined after they got going. And the reason for that, if you don't mind me saying, is because Accenture needed to be brought in in an urgent situation to take over for a contractor that was leaving. And so they agreed to an initial amount. And this was before my time. And then agreed

that they would come back after they got started, started the transition from CGI. And then they would come to terms with how much the scope ought to be.

Mr. GINGREY. Mr. Slavitt, in my remaining time, let me ask you this. You have been with CMS now for what, 3 weeks?

Mr. SLAVITT. Three weeks.

Mr. GINGREY. And you are the number two guy there, right?

Mr. SLAVITT. Correct.

Mr. GINGREY. You know, when—back in 2009/2010 timeframe when we marked up this Bill, a lot of us on this side of the aisle felt like that if the American people were going to have this Affordable Care Act—un-Affordable Care Act forced down their throat, that members of Congress and members of the administration, the President, cabinet members, political appointees like yourself—you are not a career bureaucrat—

Mr. SLAVITT. That is correct.

Mr. GINGREY. You have been appointed by the President to come into this important position. We felt, and still feel—many of us still feel that you ought to eat your own dog food. And members of Congress, I think it is appropriate, we are doing that. We had to come off the Federal Employee Health Benefit Plan and get on the DC health link. And yet you members of the administration, the President and his family really ought to be doing the same thing. If—I know you worked in IT. But let us just say if you worked for Ford Motor Company, would you drive a Chevrolet? I kind of doubt it.

Mr. SLAVITT. I would hope not.

Mr. GINGREY. I think you probably would drive a Ford.

Mr. SLAVITT. I would—

Mr. GINGREY. But what do you think about that in these remaining few seconds? Respond to me. Do you think it would be appropriate as a show of good faith to the American people that you guys and gals that are running this show that forced it upon us would be in the same plan that the American people have to be in?

Mr. SLAVITT. My understanding is that the President and his family are on the exchange. I don't know this for a fact. But that is my understanding. And if it is determined that the rest of us should be on the exchange, I would happily do that.

Mr. GINGREY. Well, if you—if that is true, please let me know. And I know we are limited in time. And I yield back, Mr. Chairman.

Mr. SLAVITT. OK.

Mr. MURPHY. I thank the gentleman to yield back. I now recognize Mr. Green for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman. And to my good friend and colleague from Georgia—who I am going to miss—I not only drive Chevys, but I am also on the plan. We had to buy ours through our exchange. And so—but I want to thank the chairman and ranking member and our witness for testifying.

For decades, the United States has had the highest rate of uninsured in the industrialized world. This drives up costs and puts families at risk of bankruptcy when they get sick. The main reason is why we have a health sick system rather than a healthcare system, because millions of Americans can't get the care they need outside the emergency room. In our own district in Texas, a very

urban district, the Affordable Care Act's enabled almost 20,000 people previously uninsured to get quality, affordable coverage. Overall, the insurance rate in our district has fallen by 8 percent. Fifty-two thousand people in the district would have had access to coverage if Texas had expanded Medicaid, and hopefully we will still get to that.

Earlier this month, the New England Journal of Medicine—not Fox News, not a left- or right-wing Internet site, but the New England Journal of Medicine—released two reports on coverage under the ACA. And I would like to read a quote from them: “With continuing enrollment . . . the numbers of Americans gaining insurance for the first time—or insurance that is better in quality or more affordable than their previous policy—will total in the tens of millions.”

And, Mr. Chairman, I would like to ask unanimous consent to place that article in the record.

Mr. MURPHY. Without objection.

[The information follows:]

## HEALTH POLICY REPORT

Mary Beth Hamel, M.D., M.P.H., *Editor***Health Care Coverage under the Affordable Care Act —  
A Progress Report**

David Blumenthal, M.D., M.P.P., and Sara R. Collins, Ph.D.

With politicians and pundits clamoring in the background, the first open-enrollment period — created by the Affordable Care Act (ACA) for Americans seeking insurance coverage in the new individual marketplaces — came to a close on March 31. There were last-minute extensions by the Department of Health and Human Services and by certain states, but for most insurance seekers, March 31 was the last chance to enroll through the individual marketplaces until the next open-enrollment period launches in November.

Americans who did not have qualified health insurance when open enrollment ended and who do not qualify for an exemption will incur a penalty of \$95 or 1% of their income over the tax-filing limit (whichever is greater) when they file income taxes on April 15, 2015. Those with incomes between 100% and 400% of the federal poverty level are eligible for subsidies to help purchase insurance, but they must purchase plans from the marketplaces to get these funds.

If this combination of penalties and incentives did not stimulate substantial numbers of previously uninsured Americans to obtain coverage, opponents would have had strong new arguments against the ACA's viability. As proponents and many experts predicted, however, a late surge pushed the number of enrollees through individual marketplaces to 8 million, which exceeded the much cited predictions by the Congressional Budget Office (CBO).

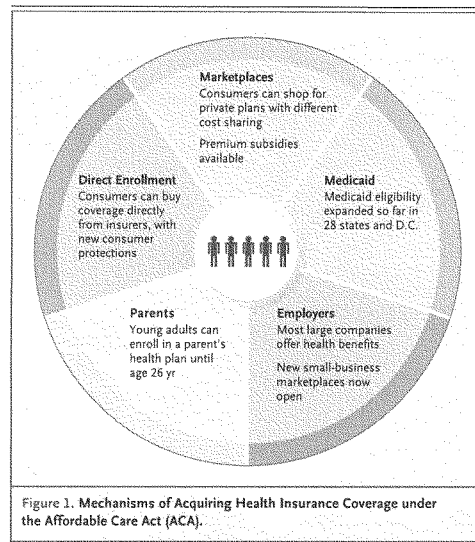
Controversy continues, however, about the importance of this and virtually every other number associated with the ACA. This report aims to help readers understand recently announced enrollment numbers, as well as other numbers that have received less attention, and assess their importance for the future of the ACA and our health care system. Ultimately, the

success of the coverage expansions of the law will be judged by their effect on a set of variables: the numbers of uninsured Americans, the adequacy of insurance (which will perhaps best be judged by the number of people who remain underinsured), and the affordability of private coverage.<sup>1</sup> It may take years, however, before we can render a considered judgment on these critical outcomes. In the meantime, an impatient public and battling politicians want progress reports.

In assessing the record of the ACA to date, we comment on enrollment not only through the individual marketplaces but also through other critical vehicles for extending coverage: the requirement that private insurers cover children of enrollees until the age of 26 years, the expansion of Medicaid eligibility, new insurance-market rules that enable people to more easily buy plans directly through insurance companies outside the individual marketplaces, and marketplaces created for small businesses, known as the Small Business Health Options Program (SHOP) (Fig. 1). We also report on early survey data about recent trends in rates of insurance since the passage of the ACA.

**COVERAGE GAINS FOR YOUNG ADULTS  
BEFORE 2014**

Though the major coverage expansions began this year, the law launched reforms in 2010 that were designed to improve health insurance and expand coverage to high-risk groups. Among the most visible of these provisions is the requirement that all health plans offering dependent coverage allow young adults to enroll in a parent's policy until they turn 26 years of age. Last year, a Commonwealth Fund survey showed that 7.8 million adults between the ages of 19 and 25



years were enrolled in a parent's plan — and that most of these enrollees would not have been eligible to do so before the passage of the law.<sup>2</sup> Federal surveys suggest that the number of young adults without health insurance has declined by 1 million to 3 million since the provision took effect.<sup>3-5</sup>

The young-adult provision has been popular across the political spectrum. The Commonwealth Fund survey showed that young adults who identified themselves as Republicans were enrolled through their parents' policies in greater numbers than were those who identified themselves as Democrats.

#### MAJOR COVERAGE EXPANSIONS UNDER THE ACA

The major coverage provisions of the ACA went into effect in January 2014. First, the law instituted new national standards for private insurance sold to individuals and small groups in the United States. Insurers selling health plans in these markets can no longer set prices on the

basis of health or exclude coverage of preexisting health conditions, and they are limited in what they can charge older adults as compared with younger adults. In addition, all plans that are sold in these markets must meet comprehensive benefit standards. Cost sharing such as deductibles may vary across plans, but to aid consumer decision making, health plans must be sold at four distinct levels of actuarial value (i.e., the share of medical costs covered on average). For example, on average, bronze plans must cover at least 60% of medical costs, silver 70%, gold 80%, and platinum 90%.

Second, the law created new private insurance marketplaces in all 50 states and the District of Columbia to sell subsidized insurance to individuals and small groups. Fourteen states and the District of Columbia chose to run these marketplaces themselves in 2014. The rest of the states left this wholly or partly to the federal government.

Third, the ACA substantially expanded eligibility for the Medicaid program. The 2012 Supreme Court decision made state participation in the law's expansion optional. As of now, 28 states and the District of Columbia are moving forward on expansion, including 6 states that are pursuing customized approaches requiring federal approval.

#### INDIVIDUAL MARKETPLACES

The experience with individual marketplaces has received disproportionate attention in the media and in political debate. The enrollment figure of 8 million that was announced in late spring with such fanfare refers exclusively to new enrollees in these marketplaces. The overwhelming focus on this particular aspect of the ACA became inevitable as soon as the troubled launch of the individual marketplaces created an irresistible narrative of government incompetence and seemed to confirm opponents' predictions of the law's failure. As a result, rightly or wrongly, the experience with individual marketplaces has become a kind of acid test for the success or failure of the ACA as a whole.

Several aspects of the individual marketplaces deserve attention as we judge their past and prospective performance. First, enrollment is not the same as insurance. Critics have questioned whether enrollees will actually pay their pre-

miums and become insured. State and federal officials, using data provided by insurance companies, estimate that 80 to 90% of enrollees have paid their first month's premiums. But it will be important over time to assess whether individuals using the 51 marketplaces pay their premiums each month. The fact that 85% of people who selected a plan during open enrollment were eligible for premium subsidies will undoubtedly influence this outcome, since the subsidies dramatically lower their premium contributions, but so will other factors, such as premium levels, cost-sharing obligations, and restrictions on provider choice, which will influence purchasers' perception of the value of the insurance they are buying.

Second, the 8-million enrollment figure is just the beginning for the individual marketplaces. The CBO projects that 25 million people will have insurance through the marketplaces by 2017. Although ongoing outreach efforts will be critical to inform those eligible about their coverage options, it is easy to see how the current number will grow. There will be annual open-enrollment periods, with the next one scheduled for November 2014 through February 2015. Individuals can also enroll at any time they lose insurance as a result of an important life event, such as marriage, or a job change. An estimated 4 million people may gain health insurance this way this year during the months between the open-enrollment periods.<sup>6</sup>

Third, despite the media focus on federally run marketplaces, the 14 states running their own systems will have a major influence on the numbers of people gaining coverage. States with well-functioning systems, such as California, New York, Rhode Island, Connecticut, and Kentucky, contributed substantially to the enrollment numbers (Fig. 2).

But HealthCare.gov was not the only malfunctioning website. Several states, including Hawaii, Minnesota, Maryland, Massachusetts, and Oregon, had severe technical failures with their online-enrollment mechanisms that have left some of these systems still largely inoperable. Maryland is replacing its online platform with Connecticut's much-lauded technology; Oregon may adopt the federal platform for 2015 enrollment. If these states overcome their technical difficulties, they will provide another boost to enrollment.

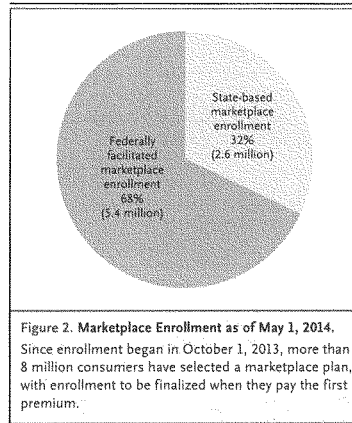


Figure 2. Marketplace Enrollment as of May 1, 2014. Since enrollment began in October 1, 2013, more than 8 million consumers have selected a marketplace plan, with enrollment to be finalized when they pay the first premium.

#### ENROLLMENT OUTSIDE THE NEW ACA MARKETPLACES

Preoccupation with the individual marketplaces obscured another important effect of the ACA: increased enrollment outside the marketplaces. The law's new regulations affecting private health insurance that is sold to individuals and small employers in the United States protect consumers and small companies, whether they buy plans in the new ACA marketplaces or outside them in traditional insurance markets. This creates another entry point to coverage for people who previously would have faced exorbitant premiums or been shut out of the market altogether because of age or preexisting health conditions. And of course, the individual mandate creates added incentives for individuals to sign up. Recent CBO estimates project that 5 million people may gain coverage this year directly from insurers.<sup>7</sup>

#### CANCELED POLICIES

A political firestorm erupted last fall when people with individual market coverage that did not meet the law's minimum standards received notices from their insurance carriers that their policies would be canceled for the 2014 coverage year. The law had clear provisions that only people with insurance policies that were active when

the law was signed in March 2010 would be “grandfathered” — that is, allowed to keep coverage that did not comply with the ACA’s new regulatory requirements. This exemption did not extend to individuals who purchased coverage thereafter. In advocating for the ACA before its passage, President Barack Obama promised that anyone who liked their insurance would be able to keep it under the new law. In hindsight, his assurances should have been more nuanced.

Nevertheless, some of the cancellations would have occurred in the absence of the ACA. Health-policy expert Benjamin Sommers and colleagues point out that there was significant turnover in the individual market before the ACA went into effect: between 2008 and 2011, only 42% of people who started out with such coverage still had it after 1 year.<sup>8</sup> Nevertheless, some plans were probably canceled because they did not meet the ACA standards requiring that all insurance products provide minimal levels of coverage and benefit. A December 2013 Commonwealth Fund survey reported that one in five adults with individual insurance had received a cancellation notice from their insurer.<sup>9</sup> The Obama administration sought to mitigate the political fallout by giving states discretion to allow insurers to renew health plans that were not compliant with the law’s standards. A total of 38 states have decided to allow renewals.<sup>10</sup> Estimates by RAND suggest that about 500,000 people may have renewed noncompliant policies.

#### THE RISK POOL AND 2015 PREMIUMS

Even with subsidies, buying insurance can be a stretch for many individuals. Premiums in 2014 were 16% lower than predicted by the CBO.<sup>11</sup> But the new insurance-market reforms under the law certainly had different effects on different people and small businesses, depending on how they were rated in the individual and small-group markets under pre-ACA pricing practices. Healthy and young people and businesses may have seen their rates increase under the ACA, whereas those in poorer health probably had lower premiums for more comprehensive coverage. The questions are, What will happen to premiums in 2015, and what will be the effect on coverage?

One of the most important determinants of premiums is how insurance companies project

medical expenses that will be incurred by their members. To make these projections, actuaries assess the health care risks in the pool of customers they insure, known as a risk pool. Projected 2015 premiums, which are already being released in some states, will reflect company estimates of their 2015 risk pools. The age of enrollees has attracted the most attention from the media as a determinant of risk, but age is just a proxy for health status.

As expected, enrollment among 18-to-34-year-olds surged as the March 31 deadline approached, climbing from 27% of total enrollment in February to 31% in the month of March. It is widely agreed that there is no single desired rate of young-adult participation. What really matters is whether the observed rate turns out to be consistent with the projections of insurance companies for any period — that is, whether the 31% participation is about what the companies expected for 2014. If young-adult participation fell short of expectations, this could prompt rate increases in 2015. However, even if participation in the pools skews to an older age than companies predicted, an analysis by the Kaiser Family Foundation showed that 2015 premiums might increase by only 1 to 2% to offset higher-than-expected costs.<sup>12</sup> This modest projected effect of an older pool reflects the fact that under the law, health plans can still charge an older person a higher premium than a younger person.

Another factor that will militate against dramatically increased 2015 rates is the risk-sharing programs of the ACA, including the so-called transitional-reinsurance and risk-corridor programs, which protect insurers and consumers against dramatic premium hikes.<sup>13</sup> Carriers with higher-than-expected claims will receive reinsurance payments, for example. This factor alone reduced premiums by 10% in 2014 and will continue to play an important role in limiting premium increases in 2015.

#### NARROW NETWORKS

One explanation for relatively modest premiums in 2014 was the widespread use of restricted or “narrow” provider networks in marketplace plans. Such narrow networks require that enrollees use lower-price providers and often charge patients more when they go out of network.

Insurers are likely to continue to use narrow

networks as a strategy to keep premiums affordable. The question is how these restrictions on choice affect the actual or perceived value of the insurance products that are sold in the marketplaces. If the quality is lower as a result of such restrictions or consumers feel they cannot get the care they need, they may stop purchasing new insurance plans, thus defeating the purpose of the law. The federal government is aware of this problem and recently announced it would examine the adequacy of narrow-network plans in the federally run marketplaces for the enrollment period next year. Several states are also developing regulations or legislation to address the issue.

The unavoidable truth is that the growth of premiums will continue as long as health care costs grow.<sup>14</sup> Narrow networks are just one solution that health plans are likely to use. The long-term success of the ACA is linked inextricably to the affordability of health care in the United States, a larger problem that the law addresses through other provisions that have drawn far less attention than the enrollment numbers.

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#### MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM

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In analyses of the success of the ACA in reducing the number of uninsured Americans, the Medicaid provisions of the law are likely to prove to be as important as its private insurance-market programs. The expansion of eligibility for Medicaid to people with incomes up to 138% of the poverty level is the largest such expansion since the inception of the program in 1965. Before this expansion, only people with low incomes who fell into certain categories (children, parents, pregnant women, people with disabilities, and those >65 years of age) were eligible. The expansion in Medicaid eligibility is also well financed from the perspective of the states. The federal government is covering 100% of the costs for most states through 2016, before gradually reducing its contribution to 90% for all states by 2020. This new financing translates into an infusion of federal dollars into states to the tune of \$800 billion through 2022.<sup>15</sup>

Despite the economic and health care rationale for expanding Medicaid, state officials who are opposed to the ACA have refused to allow this expansion in many states. In such states,

people with incomes at or above 100% of the federal poverty level can apply for subsidies for private plans in the marketplaces. But those with incomes below the poverty level cannot apply for such subsidies, since drafters of the ACA assumed that the poor would be eligible for Medicaid. In the states that have not yet expanded their programs, nearly 5 million uninsured people with low incomes are expected to be left out of the new coverage options this year.

Despite these facts, 6 months after the launch of the coverage provisions of the ACA, 6 million people had enrolled in Medicaid or the Children's Health Insurance Program (CHIP). This tally includes people who were found to be eligible as they sought insurance through federal and state marketplaces or through other means. Many individuals who went to online marketplaces were informed of their Medicaid eligibility. Consequently, this figure also includes people living in nonexpansion states who were found to be eligible under their state's preexisting Medicaid and CHIP programs. The CBO is now projecting that new enrollment in Medicaid and CHIP will reach 7 million this year and 13 million eventually. Even with uncertainty about state participation, this means that 46 million people — or 17% of the nonelderly U.S. population — could be enrolled in Medicaid or CHIP by 2018.

If history is a guide, most states will ultimately expand their programs. The fiscal benefits to states are enormous, and hospitals and other providers generally favor participation. Medicaid was launched in 1966, but it took until 1972 for participation to become widespread. Arizona held out until 1982.

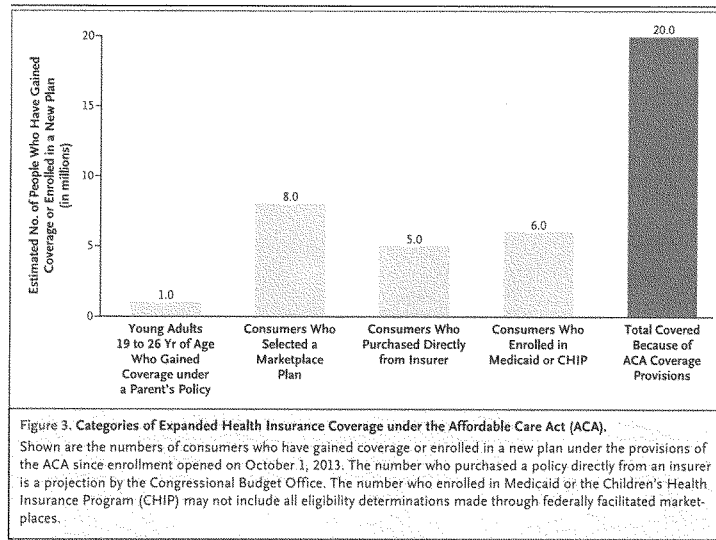
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#### REFORMS FOR SMALL BUSINESSES

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The final way in which Americans will gain coverage under the ACA is through their employers. The law imposes penalties on employers with 50 or more full-time employees who do not offer health insurance, or who offer inadequate health insurance, if an employee becomes eligible for subsidized coverage through the marketplaces. This so-called employer mandate was delayed to 2015 for employers with 100 or more employees and to 2016 for those with 50 to 99 employees.

But although the majority of large employers offer health insurance, small employers have



struggled to offer affordable coverage to employees, paying on average 18% more in premiums than large employers.<sup>16</sup> Similar to individuals who had to buy coverage on their own, small businesses that sought coverage in the small-group market were often charged higher premiums because of the health of their workforces and other factors. Many small employers, particularly those with older workforces or those in industries in which workers are exposed to health risks, could find private insurance easier and cheaper to buy under the ACA. The reforms in the small-group market are similar to those in the individual market. The law also requires that each state have a SHOP, a small-business marketplace designed to meet the needs of small employers. This year, small employers can buy plans through the SHOPS in most states, but the small-business marketplaces are not fully operational in some states because the federal government delayed certain aspects of the SHOP implementation until 2015. So far, there are no national estimates of enrollment in the SHOPS. A similar set of provisions under the Massachu-

setts reform law led to an increase in the share of small employers who offered coverage. It is too early to tell how many people may be gaining coverage through employers because of these new provisions.

#### THE RECORD TO DATE

Taking all existing coverage expansions together, we estimate that 20 million Americans have gained coverage as of May 1 under the ACA (Fig. 3). We do not know yet exactly how many of these people were previously uninsured, but it seems certain that many were. Recent national surveys seem to confirm this presumption. The CBO projects that the law will decrease the number of uninsured people by 12 million this year and by 26 million by 2017. Early polling data from Gallup, RAND, and the Urban Institute indicate that the number of uninsured people may have already declined by 5 million to 9 million and that the proportion of U.S. adults lacking insurance has fallen from 18% in the third quarter of 2013 to 13.4% in May 2014.

However, these surveys may underestimate total gains, since some were fielded before the late March enrollment surge and do not include children. With continuing enrollment through individual marketplaces, Medicaid, and SHOP, the numbers of Americans gaining insurance for the first time — or insurance that is better in quality or more affordable than their previous policy — will total in the many tens of millions.

As we look to the future of the coverage provisions of the ACA and their effect on the U.S. health care system, several observations seem justified. First, as the number of individuals benefiting from the law grows, its wholesale repeal will grow less likely, although the law could still be importantly modified in the future.

Second, experience with the ACA will vary enormously among states. Those deciding not to expand Medicaid will benefit far less from the law, and since many of these states have high rates of uninsured residents and lower health status, the ACA may have the paradoxical effect of increasing disparities across regions, even as it reduces disparities between previously insured and uninsured Americans as a whole.<sup>27</sup>

Third, the sustainability of the coverage expansions will depend to a great extent on the ability to control the overall costs of care in the United States. Otherwise, premiums will become increasingly unaffordable for consumers, employers, and the federal government. Insurers who seek to control those costs through increasingly narrow provider networks across all U.S. insurance markets may ultimately leave Americans less satisfied with their health care. Developing and spreading innovative approaches to health care delivery that provide greater quality at lower cost is the next great challenge facing the nation.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the Commonwealth Fund, New York.

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## SPECIAL REPORT

## Health Reform and Changes in Health Insurance Coverage in 2014

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Munira Z. Gunja, M.P.H., Amy Burke, Ph.D., and Audrey M. McDowell, M.S.

Open enrollment under the Affordable Care Act (ACA), the most ambitious attempt to expand health coverage in the United States in decades, began October 1, 2013. The law offers Medicaid eligibility to citizens and qualified legal immigrants with incomes at or below 138% of the federal poverty level in participating states and tax credits for private insurance purchased via marketplaces for persons not eligible for Medicaid who have incomes between 100% and 400% of the federal poverty level.<sup>1</sup> The effect of these provisions on insurance coverage and access to care is of critical policy interest.

Preliminary reports from rapid-turnaround surveys have described a decline in the uninsured rate since the fall of 2013, when open enrollment began.<sup>2-5</sup> However, numerous factors, including the economy, survey sampling error, and preexisting trends, can affect estimated rates of Americans without insurance. More generally, the systemic changes brought by the ACA pose a particular challenge for identifying the effect of the law, owing to the lack of a control group. Although to date 24 states have not expanded Medicaid, the ACA has major implications for these states, owing to subsidized marketplace coverage, the individual mandate, and a streamlined application process for uninsured persons who were previously eligible for Medicaid.<sup>6</sup> An additional question is how quickly any coverage changes will lead to improved access to care.

Our study had two main objectives. We wanted to determine, first, whether the pattern of recent coverage changes is consistent with early effects of the ACA and, second, whether any changes in access to care are yet evident.

### METHODS

#### ANALYTIC APPROACH

We used three approaches to test for associations between the ACA open-enrollment period and coverage changes, using the largest national daily poll on health issues, the Gallup–Healthways Well-Being Index (WBI). First, we assessed coverage changes in the fourth quarter of 2013 and the first two quarters of 2014, using multivariate regression to adjust for the preexisting trend and potential confounders such as employment, income, and demographic characteristics.

Second, we tested for differential effects in the subgroups most likely to gain insurance under the ACA. As noted above, the ACA affects all states; however, coverage gains should vary according to income and state decisions regarding Medicaid expansion. Newly available subsidized coverage under the ACA is targeted to low-income adults ( $\leq 138\%$  of the federal poverty level) in states expanding Medicaid and middle-income adults (139 to 400% of the poverty level) in all states. Adults with income that is greater than 400% of the poverty level may experience changes due to the mandate, cancellations of previous plans,<sup>7</sup> and other regulations, but these effects are likely to be smaller than for other groups.

Third, we tested for an association between survey-reported coverage changes and state-level marketplace and Medicaid enrollment statistics from the Department of Health and Human Services (HHS). Although HHS enrollment reports capture data both on persons who were

uninsured previously and on those who had coverage beforehand, if insurance changes are due to the ACA, these state statistics should be correlated with survey-reported coverage gains. Last, we tested for any changes in access to care using a similar multivariate approach.

#### DATA SOURCES

The most widely cited estimates of the uninsured population come from surveys conducted by the U.S. Census Bureau and the National Center for Health Statistics, which feature nationally representative sampling and high response rates, with the use of mailed and in-person interviews. However, they feature a time lag ranging from 6 to 18 months. Thus, early estimates of the effects of ACA coverage must rely on other sources.

Our primary data set was the Gallup–Healthways WBI, purchased from Gallup, for January 1, 2012, through June 30, 2014. The WBI is a daily telephone survey that asks a national sample of adults questions about health insurance, access to care, and health status. Like other data sets analyzed to describe coverage changes in 2014, the WBI is a rapid-turnaround survey with a much lower response rate (11%, on the basis of Response Rate 3, as defined by the American Association for Public Opinion Research) than government-conducted surveys.<sup>8</sup> Previous research validated WBI estimates of the uninsured rate, as compared with well-established government-conducted surveys, with year-to-year correlations (2008–2011) with the American Community Survey and Current Population Survey of 0.87 and 0.85, respectively, and state-level correlations of 0.95 and 0.89, respectively.<sup>8</sup> Although the WBI has undergone some changes since 2011 — including a reduction in sample size — questions for the outcomes studied here (see the Supplementary Appendix, available with the full text of this article at NEJM.org) have not changed. Even after the sample-size reduction, the WBI still has by far the largest sample among these rapid-turnaround data sources (with approximately 30,000 nonelderly [ $<65$  years of age] adults surveyed in each quarter, as compared with 2500 to 7500 adults in other surveys<sup>2,5,9</sup>).

We compared WBI survey data with HHS enrollment statistics for Medicaid and marketplace coverage in each state during the open-enroll-

ment period. These statistics are based on administrative data collected by the federally facilitated marketplace and data submitted to the Centers for Medicare and Medicaid Services by state-based marketplaces (see the Supplementary Appendix). We also used information on state decisions regarding Medicaid expansion as of January 2014.<sup>10</sup>

#### STATISTICAL ANALYSIS

The sample included adults 18 to 64 years of age. Our study period was January 1, 2012, through June 30, 2014. Our primary model did not include data from before 2012, because coverage was changing rapidly during this period for several million adults owing to the provision in the ACA enabling young adults to stay on their parents' insurance plans until 26 years of age. This means that our results do not capture effects of that provision, which has been well studied in previous research.<sup>11–16</sup> Similarly, our analysis does not estimate coverage gains from early Medicaid expansions that began in 2010 and 2011, which were generally much more limited than the 2014 changes.<sup>17</sup> Our sample excluded adults 65 years of age or older, who are overwhelmingly enrolled in Medicare and thus ineligible for the coverage expansion under the ACA. The sample included 420,449 adults.

The primary outcome was insurance status at the time of the survey (insured vs. uninsured), and the secondary outcomes were two measures of access to care — having a personal doctor and having difficulty paying for medical care in the past year. The WBI has been validated for these measures, but it less reliably distinguishes between different types of coverage (e.g., Medicaid vs. private insurance).<sup>8</sup> We used multivariate regression to model the likelihood of each outcome over time. The primary analysis modeled a linear monthly time trend, with sensitivity analyses that either added a quadratic time trend or did not include a time trend. We created binary variables for the beginning of the open-enrollment period (fourth quarter of 2013), for the beginning of the new coverage options (first quarter of 2014), and for the first full quarter after open enrollment (second quarter of 2014).

These variables measured any change in outcome at that point in time as compared with the baseline trend (before October 2013). Some pre-

vious analyses have focused on changes in coverage comparing the fourth quarter of 2013 with the first quarter of 2014,<sup>3</sup> which may underestimate the effect of the ACA, since some people applying in the fall of 2013 were probably already eligible for Medicaid and were enrolled as a result of greater awareness regarding coverage options under the ACA.

All models (see the Supplementary Appendix) were adjusted for demographic and economic covariates: age, race, ethnic group, sex, household income, employment status, and state of residence. We also analyzed results for subgroups based on age, sex, and race or ethnic group.

We conducted a stratified analysis that was based on household income level and state decisions regarding Medicaid expansion. Gallup asks respondents to report household income in categories ranging from \$0 to \$10,000 per month and does not impute missing values. To convert income information and household size into a percentage of the federal poverty level, we used the midpoint of each income range and imputed missing values using a multivariate regression model, as in prior research (see the Supplementary Appendix).<sup>8</sup> We then analyzed distinct income groups in states that were expanding Medicaid versus in states that were not: up to 138% of the federal poverty level (eligible for Medicaid in states with Medicaid expansion), 139 to 400% of the poverty level (eligible for tax credits in all states), and more than 400% of the poverty level (not eligible for subsidized coverage). We also compared the effect of state decisions regarding Medicaid expansion using a differences-in-differences analysis for low-income adults in states with Medicaid expansion versus those in states without Medicaid expansion.

We then compared survey-based coverage changes with enrollment reports from the HHS,<sup>18</sup> dividing the total enrollment in each state by the size of its nonelderly population. This HHS enrollment variable captured the approximate percentage of the state population that signed up for ACA-related coverage through the marketplaces by the end of March 2014. We used the same regression approach as above, with the addition of an interaction term between the second quarter of 2014 and the HHS enrollment variable. This measured the relationship between the changes in the uninsured rate

in the second quarter of 2014 and the per capita HHS enrollment statistics in each state. This analysis used robust standard errors clustered at the state level.

For ease of interpretation, we expressed our results as adjusted changes in the probability of each outcome, on the basis of linear probability models. Logistic-regression models — with results converted to predicted probabilities — produced nearly identical results.

This project was exempt from review by an institutional review board under federal regulations since it used deidentified secondary data. Analyses were conducted with the use of Stata software, version 12.0 (StataCorp), to account for the stratified survey design. Estimates were calculated with the use of nationally representative survey weights from Gallup, which were based on national targets according to age, sex, race or ethnic group, educational level, geographic region, and telephone status (see the Supplementary Appendix).

## RESULTS

### DESCRIPTIVE STATISTICS

Table 1 presents descriptive statistics for the sample. The average age of the respondents was 41.1 years. A total of 63% of the sample was white, 15% Hispanic, and 10% black.

### UNADJUSTED TRENDS IN INSURANCE COVERAGE

Figure 1 shows the unadjusted trends in the percentage of adults 18 to 64 years of age who did not have health insurance. The uninsured rate was just above 20% for most of 2012, before a slight rise in the early part of 2013. The uninsured rate was 21.0% in September 2013, right before the beginning of the open-enrollment period, and it fell to 16.3% in April 2014. The uninsured rate was stable from April through June 2014, after the end of open enrollment.

### ADJUSTED CHANGES IN COVERAGE ASSOCIATED WITH OPEN ENROLLMENT

Table 2 presents adjusted estimates of the change in coverage associated with open enrollment. As compared with the baseline trend, the percentage of adults without insurance had declined by 5.2 percentage points ( $P<0.001$ ) by the second quarter of 2014. Adding a quadratic time trend,

Table 1. Characteristics of the Study Sample.\*

Variable	Respondents (N=420,449)	Unweighted No. of Respondents
Mean age (yr)	41.1	NA
Male sex (%)	50	220,137
Race or ethnic group (%)†		
White non-Hispanic	63	288,629
Hispanic	15	44,640
Black non-Hispanic	10	33,708
Asian non-Hispanic	2	8,390
Other	8	33,028
Do not know or declined to answer	2	12,054
Household income (%)		
≤138% of FPL	14	36,102
139–400% of FPL	58	217,338
>400% of FPL	28	167,009
Currently employed (%)	71	306,153

\* The results in the table show the authors' analysis of survey data from the Gallup–Healthways Well-Being Index, 2012–2014. All estimates were calculated with the use of nationally representative survey weights; the unweighted numbers are also provided. Percentages may not total 100% because of rounding. FPL denotes federal poverty level, and NA not applicable.

† Race and ethnic group were self-reported.

omitting the time trend, or considering alternative timeframes (2013–2014 and 2010–2014) produced estimates of declines ranging from 4.2 to 7.1 percentage points ( $P<0.001$  for all comparisons) (Table S1 in the Supplementary Appendix). Declines in the uninsured rate were significant ( $P<0.001$ ) for all subgroups on the basis of age, sex, and race or ethnic group, with the largest changes occurring among Hispanics, blacks, and adults 18 to 34 years of age.

Table 3 shows changes in coverage on the basis of household income level and state Medicaid-expansion plans. By the second quarter of 2014, there had been a decline of 6.0 percentage points ( $P=0.006$ ) in the uninsured rate for persons with incomes at or below 138% of the federal poverty level in states with Medicaid expansion and a nonsignificant decline of 3.1 percentage points ( $P=0.13$ ) in states without Medicaid expansion. As compared with the baseline trend, the uninsured rate declined for persons with incomes of 139 to 400% of the federal poverty level both in states with and in those without

Medicaid expansion (–9.0 percentage points and –5.5 percentage points, respectively;  $P<0.001$  for both comparisons). In an analysis directly comparing low-income adults in states with Medicaid expansion versus those in states without, Medicaid expansion was associated with a reduction of 5.1 percentage points ( $P=0.01$ ) in the uninsured rate in 2014, as compared with states without Medicaid expansion (Table S1 in the Supplementary Appendix). Results from Table 3 were similar when we excluded persons with missing income information from the analysis instead of imputing those values (Table S2 in the Supplementary Appendix).

#### ASSOCIATION WITH HHS ENROLLMENT STATISTICS

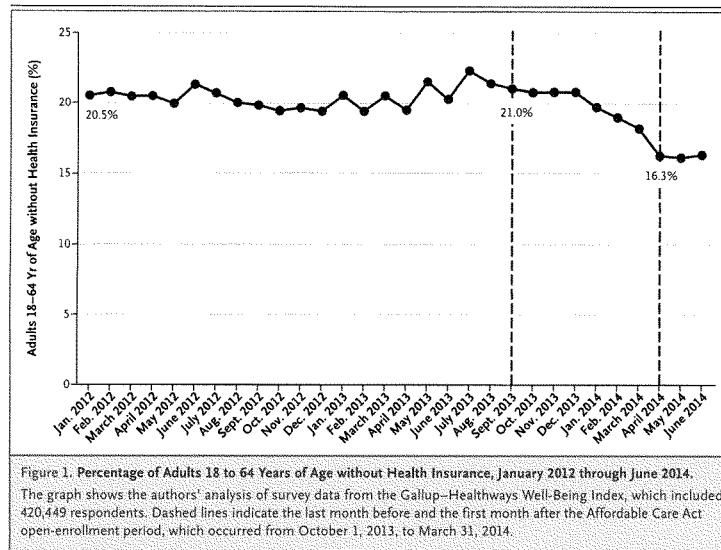
Survey-reported coverage changes were significantly associated with state-level per capita HHS enrollment statistics (Table S3 in the Supplementary Appendix). The coefficient of –0.53 ( $P<0.001$ ) indicated that each percentage-point increase in HHS enrollment was associated with a decline of 0.53 percentage points in the uninsured rate in the state. The coefficient for the second quarter of 2014 in this model was still significant (–2.4,  $P<0.002$ ), indicating that a portion of the decline in the uninsured rate in that quarter was not directly associated with HHS state-level enrollment statistics.

#### MEASURES OF ACCESS TO CARE

We also detected significant changes in access to care in 2014, as compared with baseline trends. By the second quarter of 2014, there had been an increase of 2.2 percentage points in the likelihood of having a personal doctor ( $P<0.001$ ) and a decrease of 2.7 percentage points in the proportion of adults unable to afford medical care ( $P<0.001$ ).

#### DISCUSSION

In this analysis of nationally representative survey data from January 2012 through June 2014, we found a significant decline in the uninsured rate among nonelderly adults that coincided with the initial open-enrollment period under the ACA. These changes remained highly significant after adjustment for potential confounders such as employment, demographic characteristics, and income. As compared with the baseline



trend, the uninsured rate declined by 5.2 percentage points by the second quarter of 2014, a 26% relative decline from the 2012–2013 period. Combined with 2014 Census estimates of 198 million adults 18 to 64 years of age,<sup>19</sup> this corresponds to 10.3 million adults gaining coverage, although depending on the model and confidence intervals, our sensitivity analyses imply a wide range from 7.3 to 17.2 million adults.

The pattern of coverage gains was consistent with the effects of the ACA, with major gains for persons likely to be eligible for expanded Medicaid on the basis of their income and state of residence but smaller and nonsignificant changes for low-income adults in states without Medicaid expansion. Coverage gains were significant both in states with Medicaid expansion and in those without Medicaid expansion for persons with incomes between 139% and 400% of the federal poverty level, which is consistent with tax subsidies under the ACA for private insurance in this income range, regardless of state decisions regarding Medicaid expansion. Absolute gains were largest among young adults and

Hispanics, two groups with high uninsured rates at baseline. State-level estimates of coverage gains were significantly associated with official HHS enrollment statistics, showing that each percentage point of the state population enrolling via the marketplaces was associated with a half-point decline in the uninsured rate. Nonetheless, the inherent lack of a control group precludes a causal interpretation for these findings, and other unmeasured factors may have contributed to these changes.

Overall, our results are consistent with the broad patterns identified previously in the Gallup–Healthways WBI and several other nongovernmental surveys,<sup>2,4,5,20,21</sup> as well as a recent review of national ACA enrollment figures.<sup>22</sup> Our study adds to these previous findings by adjusting both for potential confounders and for pre-existing trends, as well as showing that these changes were associated with ACA enrollment statistics in each state.

We found evidence that within the first 6 months of gaining insurance, more adults reported having a personal doctor and fewer had

Table 2. Changes in the Uninsured Rate among Adults 18 to 64 Years of Age in 2012–2014.\*

Population	Baseline Uninsured Rate†	First Quarter, 2014		Second Quarter, 2014	
		Change from Baseline Trend (95% CI)		Change from Baseline Trend (95% CI)	
		<i>percent</i>	<i>percentage points</i>	<i>percent</i>	<i>percentage points</i>
All respondents	20.3	–2.6 (–3.4 to –1.9)	<0.001	–5.2 (–6.0 to –4.5)	<0.001
Sex					
Male	21.8	–2.4 (–3.5 to –1.3)	<0.001	–5.0 (–6.1 to –3.9)	<0.001
Female	18.9	–2.8 (–3.9 to –1.8)	<0.001	–5.5 (–6.6 to –4.4)	<0.001
Race or ethnic group					
White non-Hispanic	14.3	–1.8 (–2.6 to –1.0)	<0.001	–4.0 (–4.8 to –3.2)	<0.001
Black non-Hispanic	22.4	–4.3 (–6.8 to –1.9)	0.001	–6.8 (–9.3 to –4.2)	<0.001
Hispanic	41.8	–3.9 (–6.4 to –1.4)	0.002	–7.7 (–10.4 to –5.1)	<0.001
Age					
18–34 yr	26.0	–3.8 (–5.3 to –2.4)	<0.001	–6.5 (–8.0 to –5.0)	<0.001
35–44 yr	21.1	–2.0 (–3.7 to –0.2)	0.03	–4.6 (–6.4 to –2.8)	<0.001
45–64 yr	15.5	–2.0 (–2.9 to –1.0)	<0.001	–4.5 (–5.4 to –3.5)	<0.001

\* All models used nationally representative survey weights and were adjusted for age, sex, race, ethnic group, employment status, household income, state of residence, and a linear time trend. Analyses also included a binary variable for the fourth quarter of 2013 (data not shown). CI denotes confidence interval.

† The baseline uninsured rate was the mean uninsured rate for the population from the first quarter of 2012 through the third quarter of 2013.

difficulties paying for medical care — even though the latter measure asked about the prior 12 months. These results are consistent with studies of previous insurance expansions that have shown that gains in coverage can lead to rapid improvements in access.<sup>13,23–26</sup>

Our study has important limitations. As discussed earlier, the response rate for rapid-turn-around data sources such as the WBI is much lower than that for government-conducted surveys.<sup>8,9</sup> However, Gallup polls and similar data sets are used regularly to offer timely evaluations of population-level phenomena, including health care–related issues<sup>27,28</sup> and elections.<sup>29–31</sup> More importantly, the WBI has been validated against government-conducted surveys for this type of analysis of the uninsured rate, although the same study concluded that the WBI does not reliably measure the type of insurance a person has.<sup>8</sup> In addition, the WBI does not provide information on children's insurance coverage, which may also change under the ACA.<sup>32,33</sup>

The income information in the WBI is limited, which means that our estimates of income as a percentage of poverty are imprecise, and previous research has shown that the survey overrepresents the middle of the income distribution.<sup>8</sup> Nonetheless, we found logical patterns of coverage on the basis of these measurements, and results were similar when we excluded observations with missing income data.

The HHS enrollment reports also have limitations. For applications sent directly to state Medicaid agencies, the HHS was unable to consistently distinguish between persons enrolling for the first time and those renewing coverage. For that reason, we used only enrollment statistics that were based on marketplace determinations of eligibility for Medicaid and private coverage, rather than those made directly by state Medicaid agencies. The reports also do not measure off-marketplace nongroup (private) coverage or employer-sponsored coverage, both of which may undergo ACA-related changes.<sup>22,34</sup>

Table 3. Changes in the Uninsured Rate among Adults 18 to 64 Years of Age in 2012–2014, According to Income Level and State Medicaid-Expansion Status.\*

Income Level	Baseline Uninsured Rate†	First Quarter, 2014		Second Quarter, 2014	
		Change from Baseline Trend (95% CI)	P Value	Change from Baseline Trend (95% CI)	P Value
	percent	percentage points		percentage points	
≤138% of FPL					
States without Medicaid expansion	60.0	1.7 (–2.1 to 5.4)	0.39	–3.1 (–7.1 to 0.9)	0.13
States with Medicaid expansion	56.1	–3.6 (–7.6 to 0.3)	0.07	–6.0 (–10.4 to –1.7)	0.006
139–400% of FPL					
States without Medicaid expansion	21.0	–4.1 (–5.5 to –2.7)	<0.001	–5.5 (–7.0 to –4.0)	<0.001
States with Medicaid expansion	18.6	–4.7 (–5.9 to –3.4)	<0.001	–9.0 (–10.3 to –7.7)	<0.001
>400% of FPL					
States without Medicaid expansion	1.8	0.4 (–0.3 to 1.0)	0.26	–1.0 (–1.6 to –0.4)	<0.001
States with Medicaid expansion	2.0	–0.4 (–1.0 to 0.2)	0.18	–0.7 (–1.3 to –0.1)	0.02

\* All models used nationally representative survey weights and were adjusted for age, sex, race, ethnic group, employment status, household income, state of residence, and a linear time trend. Analyses also included a binary variable for the fourth quarter of 2013 (data not shown).

† The baseline uninsured rate was the mean uninsured rate for the population from the first quarter of 2012 through the third quarter of 2013.

This means that the HHS statistics do not fully capture all new ACA-related enrollment, but we nonetheless detected a strong association between these figures and the uninsured rates in the survey.

Finally, although our multifaceted approach offers substantial improvements over previous reports, these analyses are merely observational. We can only identify suggestive associations between the ACA, the declining uninsured rate, and access to care.

In conclusion, we found that the number of Americans without health insurance declined significantly since the ACA open-enrollment period began in October 2013. The patterns of coverage changes were consistent with the eligibility criteria in the law regarding subsidized coverage and HHS statistics on state-level enrollment in ACA programs. National estimates of coverage after the open-enrollment period will not be available from federal surveys until late 2014, and reliable state-level estimates will not be available until the fall of 2015. Future research with these government-conducted surveys will be valuable to corroborate these find-

ings, monitor future trends, and further assess the downstream effects of coverage.

The views expressed in this article are those of the authors and do not represent the official views of the Department of Health and Human Services.

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Mr. GREEN. Thank you.

Mr. Slavitt, are you familiar with these reports?

Mr. SLAVITT. Yes, at the high level.

Mr. GREEN. Earlier this week, the Gallup Poll released their own latest total numbers of Americans having insurance. Are you familiar with that survey?

Mr. SLAVITT. Yes, I am, Congressman.

Mr. GREEN. The—similar, the Urban Institute and Commonwealth Fund conducted surveys. Can you discuss that also?

Mr. SLAVITT. I am familiar with those two, yes.

Mr. GREEN. OK. Would you agree that the findings of both Gallup and the New England Journal of Medicine are consistent with the millions of Americans signing up for healthcare?

Mr. SLAVITT. They are consistent, very encouraging.

Mr. GREEN. OK. At this point, the only thing keeping millions more Americans from signing up for the coverage is the refusal of Republican Governors and State legislatures to expand Medicaid. If they did, another 5 million Americans would be eligible for insurance.

Mr. Chairman, I think the Affordable Care Act, obviously, coming out of the chute, it was a problem. But it has been fixed. And hopefully we will see in the renewals it happen. But it is working, although a lot of us had tough times in October into mid-November who supported it.

Mr. Slavitt, what is CMS doing to address the execution of the technology lessons learned from the first enrollment section?

Mr. SLAVITT. Well, Congressman, I got to this project when it was beginning the turnaround stage at the end of October. And I think what we are doing now is essentially carrying over—just as we did in the turnaround. There is no magic to it. It is basic blocking and tackling. It is good communication. It is, quite frankly, a lot of the recommendations that have come out of the GAO report and making sure that we have precise requirements. It is daily management. It is senior level accountability that goes all the way up to the secretary.

Mr. GREEN. You know, I advocated in Texas, having served a lot of years in the State legislature, is that we should have had a Texas plan that we could have done. Some States had good examples of their plan, some not. Could you talk about that? Like, I know the State of Maryland and some other States had problems. And I don't know if they are fixed or not. But were they similar to what we had on a national scale for our States that didn't have a State plan?

Mr. SLAVITT. In terms of the challenges, or just in terms of what they got done in their State?

Mr. GREEN. Yes. Were they on a smaller scale, having the same challenges that we were?

Mr. SLAVITT. I think it is probably safe to conclude at this point, towards the end of 2014, that it was the rare State, and maybe Kentucky's one of them, that didn't underestimate how difficult this would be, given all of the complexities of tying into Medicaid, tying into insurance companies, offering a consumer Web site. In the first year of any new program, in my experience, whether it is public sector or private sector, it is sometimes bumpy. The same is

going to be true in the second year. But those problems become more and more minor, and we get better all the time.

Mr. GREEN. To the best of your knowledge, for example if a State wanted to create their own plan now, there is nothing in the law that would prohibit them from approaching CMS or HHS, either that or expanding in Medicaid coverage?

Mr. SLAVITT. That is correct.

Mr. GREEN. OK. Thank you, Mr. Chairman. I will yield back my time.

Mr. MURPHY. The gentleman yields back. I now recognize Dr. Burgess for 5 minutes.

Mr. BURGESS. Again, thank you, Mr. Slavitt, for being here. You heard my comments during the opening statement about the memorandum that Mr. Cohen suggested that I might have. And I again just want to underscore that that is important to me. And even though Mr. Cohen is no longer at CMS, I would very much like to see that.

Mr. SLAVITT. It is my understanding that we have just recently sent it. So if you don't receive it, I will follow-up with your office and make sure that you have it.

Mr. BURGESS. All right. Very well. You know, and it is kind of—I was just thinking it has been almost a year ago, really right now, that your boss, Marilyn Tavenner, was here. And we talked about some things about the upcoming launch of Healthcare.gov. But of course, that was just a little less than a month after the unilateral decision by the President to delay the employer mandate. Now, I remember asking Ms. Tavenner about how—was she involved in that decision. And she asserted that she was not. I asked her how she found out about it. And she said her chief of staff told her, which I found rather astonishing. If my chief of staff came and gave me information like that, I mean I would be curious as to where that came from. And she seemed to lack curiosity about how that decision was reached. But let me ask you this, we are a year later. The employer mandate is now supposed to kick in about a week and a half after Election Day in November. Is it your understanding that the employer mandate will in fact be enacted in November, or can we expect a further delay of that?

Mr. SLAVITT. So I am still working my way around the Federal Government, trying to understand how it all works.

Mr. BURGESS. Good luck.

Mr. SLAVITT. Thank you. My understanding—and you could please correct me if I am wrong—is that that is an IRS and Treasury area of responsibility. So I haven't been exposed to that so much yet.

Mr. BURGESS. My personal belief is that we will never see the employer mandate. I have no inside information, obviously. I am not speaking for the committee. I am just speaking for myself. When you look at the disruption that was caused in the individual market, October, November, December of last year, and remind yourself that that was only 15 percent of the insurance market that had that convulsion, had that happened to the entire—both the large group market, the small group market, the individual market all at once, it would have been pretty disruptive.

Now, you heard Mr. Gingrey talk about members of Congress and members of the administration should take the same thing people have to take. I agree with that. In fact, I did not take the BC Exchange that was offered to Members of Congress and their staff. I said, "Look, I'll do what other people in my district have to do." I went to Healthcare.gov, bought a bronze plan off the Web site. The biggest mess I have ever been involved in in my life. But I finally got through. It took about three and a half months to do so. Now, I am wondering what my rate is going to be next year. I have got the most expensive health insurance policy I have ever had, an enormous deductible. But what can I look forward to in the next insurance year? You talked about you wanted a successful open enrollment. Is it going to be successful? What are the rates going to look like?

Mr. SLAVITT. Yes. So I think we are at a stage now where—and indeed, this is one of our high measures for success, making sure that there are enough choices and enough affordability. And, of course, each State is going through their own process and going through rate reviews. We have seen some States publicly now come out with their rates. I believe Rhode Island, Washington. California today is going to have I think an announcement with what their rates are. I couldn't tell you, Congressman, about Texas, because I don't know. But generally speaking, what we have seen are rates that are in not the double digit increased levels but in the mid-single digit levels. That is not going to necessarily be the case in every county in America, but that seems to be what is happening on average.

Mr. BURGESS. But still, I mean, you mentioned that in three or four States. We have got a long way to go before renewal rates across the country are in evidence.

Mr. SLAVITT. No question. No question.

Mr. BURGESS. I mean, you are the Principle Deputy Administrator. Do you have any responsibility or involvement in the renewal or the rate filings?

Mr. SLAVITT. I think these rate filings get reviewed and approved, you know, at the State level. There is a process. And I think it is in the mid-process. I believe right now that the—

Mr. BURGESS. Let me just interrupt you, because my time is running up. Do you receive interim reports or updates on what those State filings are?

Mr. SLAVITT. I think there has been an initial submission, and I have seen a high-level report. But this is not yet final information.

Mr. BURGESS. And is your office going to make those rate filings public information? Will we have the availability to access that?

Mr. SLAVITT. When they become final, absolutely. Absolutely.

Mr. BURGESS. Again, as a Healthcare.gov member from the State of Texas of the Federal fallback, I would very much like to know what my renewal rates are for next year.

Mr. SLAVITT. Of course.

Mr. BURGESS. Thank you, Mr. Chairman. I will yield back.

Mr. MURPHY. The gentleman's time has expired. I recognize Ms. Schakowsky for 5 minutes.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

I just wanted to tell you, Mr. Slavitt, I don't know if your office and your position is actually in charge, but we have gotten tremendous cooperation from CMS when we have had constituent issues. And, you know, clearly, it comes out. Consumers get confused, have a lot of questions, have some problems. I get irritated sometimes. On the other side, I feel like there is an embracing of these problems rather than a constituent service attitude to fix the problems. And when we have tried, we have had good success. And so I just wanted to tell you I appreciate that.

I also just wanted to say that the minority staff has done a district by district, the benefits of the healthcare reform law in all the districts in the country. And it is just wonderful to see how the number of people that in my district, 283,000 people in my district, including 51,000 children and 120,000 women now have health insurance that covers preventive services without any copays, coinsurance, or deductibles. Needless to say, that is huge.

Mr. SLAVITT. Very good news.

Ms. SCHAKOWSKY. And up to 36,000 children in my district with preexisting conditions can no longer be denied coverage by health insurers. It is just lots and lots of good news, including the new Medicaid enrollees that are now being covered.

But I did have a question. So we are talking somewhat about the States that have expanded Medicaid and have not. Twenty-six States, the District of Columbia, have expanded Medicaid coverage under the Affordable Care Act. And in those States, Medicaid is seeing great success. Enrollment has increased substantially, and the percentage of the population without insurance has declined dramatically. And I am asking you, Mr. Slavitt, if you have seen studies that compare the decline in the number of uninsured in States that did and did not expand Medicaid?

Mr. SLAVITT. Yes, I have seen those studies.

Ms. SCHAKOWSKY. And can you tell me what you found?

Mr. SLAVITT. The States that have expanded Medicaid—and I will have to get back to you on the exact figure—have seen significantly lower rates of uninsured than those States that did not expand Medicaid.

Ms. SCHAKOWSKY. But we have seen a decline in any case in most—isn't it in all States?

Mr. SLAVITT. Declined in any case, and a bigger decline in States that have expanded Medicaid.

Ms. SCHAKOWSKY. And have you seen the estimates about the number of Americans that would receive healthcare coverage if all 50 States expanded Medicaid? Do you know the size of this estimate?

Mr. SLAVITT. I believe that it is an additional 5 million, if I am not mistaken.

Ms. SCHAKOWSKY. All right. Thank you. And if that is the case, and I believe you that it is, this is really an appalling number, 5 million Americans who would receive healthcare coverage if Republican Governors and State legislatures took the simple step of expanding Medicaid. It is obviously good for people when more people have health insurance.

But, Mr. Slavitt, what about healthcare providers? How does the Medicaid expansion help them?

Mr. SLAVITT. So my information is anecdotal. But it appears that if there's a dramatic reduction, or a significant reduction in uncompensated care, it appears that this has been a very good thing for providers.

Ms. SCHAKOWSKY. And this committee has spent the last 3 years looking for some Affordable Care Act-related scandal. And despite all their concern, they have systematically ignored an ongoing healthcare tragedy: the dereliction of duty by Republican Governors around the country who refuse to expand Medicaid. For those who have not been following this closely, the Affordable Care Act provides 100 percent Federal funding for the first 3 years for the States to expand Medicaid coverage to millions of low-income Americans, right?

Mr. SLAVITT. That is correct.

Ms. SCHAKOWSKY. And yet for some reason, Republican Governors in dozens of States have refused to expand coverage to low-income insured individuals in their States, correct?

Mr. SLAVITT. That is correct.

Ms. SCHAKOWSKY. Well, this to me is a real scandal. The expansion doesn't cost States a dime. It provides quality affordable coverage for millions of Americans working hard just to get by. Yet some Republican Governors and State legislatures are deliberately refusing to provide coverage to millions of uninsured Americans.

And, Mr. Chairman, that it seems to me is an issue this subcommittee really should look into. And I yield back.

Mr. MURPHY. The gentlelady yields back. I now recognize Mrs. Blackburn for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman. And thank you for being with us today. Overseeing this implementation, getting to the bottom of a lot of the questions, I think is very important, and continuing to do our due diligence. And I know that several people have mentioned the New England Journal of Medicine article from last week, the health reform and changes in health insurance coverage. And my friends across the aisle have wanted to tout that as being something to prove their point.

I think that it is important though to go in here and look at how the authors came to the conclusion that 5.2 percent more had insurance, that there was a decline in those without insurance from September 2013 to June of 2014. And then the authors mention the limitations of their study. They said that the study did not distinguish between persons enrolling for the first time and those who were changing their enrollment. And I really wonder how many of those that had to buy more expensive policies, new policies that were Obamacare compliant? How did that affect that number?

And the authors measured improvement and access to care by asking two questions. First, did the survey participants identify a personal doctor? And, second, did the survey participants report difficulty paying medical bills? Well, it seems to me a more important outcome measure would be whether a person was actually able to see the doctor. Because in our district, we hear from people they can't get access to the doctor. They have got access to the queue, because they have got a card. They can't get access to the doctor.

So while my colleagues across the aisle talk about how many people have insurance, I would like to remind everyone that having

an insurance card is not the same as having medical care. And I continue to hear from people in Tennessee who lost their health plan. They liked it. They can't keep it. I hear from people that have not been able to keep their doctor because of the narrow networks in Obamacare. I hear from people who go to the doctor and need a test, but can't get the test because their copays and their coinsurance are too high. They can't afford it. This stuff is too expensive to afford.

And, finally, we are hearing from some of our Tennessee insurance carriers, they are going to have a 19 percent increase in the health insurance premiums in 2015. So it is kind of like adding insult to injury. You have got this stuff. You can't use it because it is too expensive to afford. The copays are too high. You have an insurance card, but you can't get in to see the doctor and you are having to wait. I don't understand why my colleagues across the aisle continue to defend this thing.

But, today, we are shifting our focus to oversight and the way that taxpayer dollars—I remind everyone, taxpayer dollars are paying for this. And the people don't like it. On January 1, 2014, HHS certified to Congress that the American health benefit exchanges, the marketplace, were verifying their applicants for advanced payments of the tax credits. Cost share and reductions were indeed eligible. However, the GAO secret shopper investigation found that 11 out of 12 secret shoppers were able to obtain health insurance and qualify for premium tax credits using fictitious identities and fraudulent documents. Now, let me, for the benefit of my colleagues, talk a little bit about what a secret shopper program does.

When I had my marketing business, we would run secret shopper programs for malls and shopping centers and chambers of commerce. You would identify where your problems are. And then you get in there and you clean them up. The problem is the system allows fraud. If you have got 11 out of 12 that something is wrong, Mr. Slavitt, that is a failing grade. There had been over 30 delays in implementation. The President has made multiple unilateral changes. And, you know, we are here to learn about the contracting practices that took place at CMS with the botched implementation of this law. We are looking at the GAO study. This thing is not much better.

Let us talk about this contract. So January, CMS awarded a contract to a new company to continue work on the Federal marketplace. It was a \$91 million contract, correct?

Mr. SLAVITT. Correct.

Mrs. BLACKBURN. OK. Now, GAO says that cost has ballooned to more than \$175 million, is that correct?

Mr. MURPHY. You can answer that question.

Mr. SLAVITT. That is what the report says. I don't agree with that characterization, but it is what the report says.

Mrs. BLACKBURN. OK. Thank you. I will submit the rest of my questions. I yield back.

Mr. MURPHY. Thank you. Now, we have just been called to vote. We will go through Mrs. Ellmers' questions, and then we will take a break and come back for the second part.

Mrs. Ellmers, you are recognized for 5 minutes.

Mrs. ELLMERS. Thank you, Mr. Chairman. And thank you for being with us, Mr. Slavitt.

I would like to go back to a little bit of the discussion you had with my colleague from Ohio, Mr. Johnson. I know you had made some comments there at the end where you pointed out that, in the real world, things are much more realistic. And that ideologically, many times things seem like they are going to be better than they are. I would say to you, sir, that that is exactly why I ended up running for office, being a nurse, because I did see—and my husband, as a doctor, saw that the plan that was going forward was not going to be realistic. And I think we have learned over time that that is the case, and that there were many promises made that have not been kept—well intended, but not true for the American people. So I do share with you that same sentiment but realize, too, that that is why we feel so strongly about this issue, that the American people do need to see what can be realistic and achieved in good healthcare in this country, and good healthcare coverage.

You did also have an exchange with Mr. Johnson on the cost of Healthcare.gov, and what it should have cost. You reluctantly did not answer the question of the cost being a billion dollars, is a billion dollars too much for the implementation thus far?

Mr. SLAVITT. So thank you, Congresswoman. I have not seen a study yet which looks at what the appropriate cost for building the entire Healthcare.gov system should be. But, of course, I do acknowledge that our colleagues at the GAO pointed out that there were absolutely inefficiencies and waste in the way the contract was managed. So at the very least, we know there was some. I would hesitate to say though that it was entirely waste, because there was a really significant set of systems built. And I think those systems have significant long-term value for the country.

Mrs. ELLMERS. You know, there again, it gets back to that same issue of what is realistic, what is achievable. And, you know, simply throwing money at it, and then looking back in hindsight to determine what did work and didn't, I think we all are learning from this experience. So that, of course, has value. I don't know how you measure it. But the American taxpayers are still on the hook for this. And that is again why we are taking the approach we are, which is, when is it going to be enough? When are we going to achieve the goals at a cost effective measure?

I want to look into some of the issues with security breaches. Are you aware at this time of any problems that the Web sites—from the building of the Web site, and that there are still concerns? Are you aware of any right now?

Mr. SLAVITT. So there have been no successful malicious attacks. And, certainly to the best of my knowledge, no one's individual data has ever been compromised from the Healthcare.gov Web site.

Mrs. ELLMERS. So to the best of your knowledge, and just based on the answer that you gave, you are not seeing that there were any related information breaches in Healthcare.gov or traveling through the Federal exchanges that you would consider a security breach?

Mr. SLAVITT. We have not seen any malicious attacks that have been successful. And we have not seen anybody's personal information in any way get compromised.

Mrs. ELLMERS. What is the definition of a successful breach?

Mr. SLAVITT. Well, I am not trying to be cagy, just that nobody has successfully penetrated the security system to the best of my knowledge, Congresswoman.

Mrs. ELLMERS. Are you aware of any companies building, operating, or otherwise working on Federal exchanges, obtaining access to information that they should not have? Anyone who is outside of the system or working on—that have?

Mr. SLAVITT. Not to my knowledge.

Mrs. ELLMERS. And information on enrollees or applicants, none there as well?

Mr. SLAVITT. No, not to my knowledge.

Mrs. ELLMERS. Are you aware of any changes to site protocols or standards to address breaches to accessed information?

Mr. SLAVITT. I think it is fair to say that the security team does continuous monitoring and makes changes and puts in new patches as new—different security things have been found out about in the industry and so forth. So there is a continuous monitoring—

Mrs. ELLMERS. Can we obtain that information over time, any of the changes and updates that may have taken place for the committee?

Mr. SLAVITT. Sure. Let me figure out what I can share. I obviously don't want all of the things that our security team does to be well understood by the wrong people. But I want to make sure to get you the information you need.

Mrs. ELLMERS. OK. Thank you. Thank you, Mr. Chairman. I yield back.

Mr. MURPHY. Thank you. They have called votes.

Mr. Slavitt, we thank you for your testimony. Members will have a few days to get other questions to you. And we would appreciate a quick, thorough, and honest response.

Mrs. DEGETTE. Mr. Chairman, can I move to strike the last word, just very briefly?

Mr. MURPHY. Sure.

Mrs. DEGETTE. I just want to—Dr. Burgess had mentioned earlier that HHS didn't respond to the committee's request for an analysis of its legal authority to make payments in connection with the risk corridors program. I have just been told that HSS did respond to the request and provided a response to the committee on Jun 18, 2014. And in the response, they also included a legal analysis. So I wanted to clarify the record. And I wanted to also make sure that if Dr. Burgess, or you or the committee staff did not receive that, we will get another copy to you.

Mr. MURPHY. Dr. Burgess?

Mr. BURGESS. Well, in fact, I did not receive it. But I would be anxious to look at it and see if it answers the question as it was asked. And, Mr. Chairman, if I could have the indulgence of one brief follow-up with Mr. Slavitt?

Mr. MURPHY. Yes, very brief.

Mr. BURGESS. Mr. Slavitt, we have heard a lot of discussion about the fact that when this thing went live, the back-end part

of the system was not built. Is it now built and available and ready to use, the part that pays providers?

Mr. SLAVITT. So the part that pays the issuers, issuers are getting paid today.

Mr. BURGESS. How about the doctors and hospitals?

Mr. SLAVITT. The doctors and hospitals get paid by the health plans, not by the exchange—not by the marketplace.

Mr. BURGESS. OK. So the back-end part of the system is up and fully functional?

Mr. SLAVITT. No, no, no. The back-end part of the system is going through continuous releases. Today, we are paying the issuers on an estimated basis. There will be a coming release this year where—by the end of this year—where they will begin to get paid at a policy level basis. And then next year, continued automation will occur to tie everything into the back end of CMS' systems.

Mr. BURGESS. OK. Mr. Chairman, it just begs the question. Have the right people been paid the right amount of money? These are taxpayer dollars that are—

Mr. SLAVITT. I will follow-up—

Mr. MURPHY. What we will do is we will follow-up with some questions to you.

Mr. SLAVITT. Yes. I will be happy to follow-up.

Mr. MURPHY. Mr. Woods, we will probably reconvene—our votes will probably take us to 11:30. So this will be in a brief recess until 11:30. And we will be back. Thank you very much.

[Recess.]

Mr. MURPHY. This reconvenes the Subcommittee on Oversight and Investigations. I would now like to introduce the witness on the second panel for today's hearing. Mr. William T. Woods is the Director with the Acquisition and Sourcing Management Team at the Government Accountability Office. He provides overall direction for GAO's review of contracting activities at defense and civilian agencies.

I will now swear in the witness. Are you aware that this committee is holding an investigative hearing, and when doing so has the practice of taking testimony under oath? Do you have any objections to testifying under oath?

Mr. WOODS. None whatsoever.

Mr. MURPHY. The Chair then advised you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today?

Mr. WOODS. No, I do not.

[Witness sworn.]

Mr. MURPHY. Thank you. You are now under oath and subject to the penalties set forth in Title XVIII, Section 1001 of the United States Code. You may now give a 5-minute summary of your written statement.

**STATEMENT OF WILLIAM T. WOODS, DIRECTOR, ACQUISITION AND SOURCING MANAGEMENT, GOVERNMENT ACCOUNTABILITY OFFICE**

Mr. WOODS. Thank you, Mr. Chairman, Ranking Member DeGette. It is a pleasure to be here this afternoon to talk to you

about Healthcare.gov and the work that we have done looking into that system.

When the Web site was launched in October of last year, there were, of course, a number of problems. We got a lot of requests from the Congress to review what happened and why. Those requests came from both the House and the Senate, from both sides of the aisle. We got requests from committee chairs, from ranking members, from individual senators, individual congressmen across the board. And what we decided to do was to combine all of those requests and conduct a body of work that addressed all of the issues that were raised in those various requests. We have a number of engagements underway to address all of those issues.

The one that we will be talking about today is contracts. But let me just mention, we have one that is nearing completion on privacy and security concerns with respect to the Web site. And we also have a report that is on-track for issuance later this year on information technology management. That report will look at the use of best practices in the development of this information technology system.

But I am going to be talking today about our first report that was publicly released yesterday. And that is on the contracting aspects of Healthcare.gov. And I am going to be talking about our three objectives. The first thing we reviewed was the acquisition planning by CMS for the Web site. Secondly, we looked at the oversight of the cost schedule and performance of that system. And then, thirdly, we looked at a range of contractor performance issues with respect to Healthcare.gov.

We focused on the largest task orders and contracts that were involved here. Our report mentions that CMS had spent about \$840 million for development of the system. And that was through March. Obviously, the spending has continued, and that number is likely higher today. But as of the time that we completed our work, it was \$840 million.

And we focused on the largest. We reviewed in depth two task orders and one contract. Just briefly, those task orders are, one, first to CGI Federal for development of the federally facilitated marketplace. That is basically the Web site itself, as well as some back office systems that support the enrollment process, the financial management process, plan management, et cetera.

We also looked at a task order awarded to QSSI. And that is for the data hub. The data hub is a system that interfaces with other agencies. There are roles that other Federal agencies need to play to make this system work: the Internal Revenue Service, the Department of Homeland Security to verify immigration status, et cetera. So lots of agencies have a role here. And the data hub system is that system that allows for communication among all of those agencies.

And then the third contract that we looked at is one with Accenture. That was awarded on a sole source basis by CMS in January of this year for continued development of that federally facilitated marketplace.

Before I get to our specific findings, I just wanted to make an observation that there really are some common threads that run through all of the work that we did here. And those threads are

first of all complexity. This was an enormously complex undertaking. As I said, there were lots of Federal agencies involved, a number of States involved, industry partners, healthcare plans. Lots of players. There were also lots of systems that had to interact with each other. And that added to the complexity. Another thread that runs through—and you will see that when we get to the findings in a moment—is the pressure of deadlines. The Affordable Care Act itself set January 1, 2014, as the date when the enrollment took effect. The Department of Health and Human Services backed up from that January deadline and set an October 1, 2013, time for when the system needed to be ready to go, when they could throw the switch, the go-live date, that sort of thing. They needed to have things in place by October 1 of 2013. And that drove a lot of the decisions that were made by CMS. And then the third thread that runs through all of our findings is the changing requirements. Things were constantly evolving, which made it difficult not only for CMS personnel to keep things on track but also for the contractors to keep up with those changes. Some of those were anticipated changes, things they knew going in they did not yet know. But others were—they were learning as they went along.

Let me get into the specific findings in the three areas that I mentioned. In the area of—

Mr. MURPHY. Could you summarize, because you are already a couple minutes over? We want to ask you a number of questions, so if you could just summarize your final findings.

Mr. WOODS. Certainly. Yes.

Mr. MURPHY. Thank you.

Mr. WOODS. In the area of planning, our bottom line assessment is simple yet sobering. And that is that CMS began and undertook the development of the Healthcare.gov system without adequate planning, despite facing a number of challenges that increased both the level of risk and the need for oversight.

In the oversight area, we saw increasing costs across the instruments that we looked at. Both of the task orders experienced cost increases, and the new contract awarded to Accenture also saw cost increases. Those cost increases were due to a number of factors. As I said, some requirements were unknown at the time they awarded these instruments. When those costs became known, when those requirements became known, the costs increased. The cost schedule and performance issues were exacerbated by inconsistent and sometimes absent oversight.

And then in the third area about contractor performance, we saw primarily in the CGI Federal task order an increasing sense of frustration on the part of CMS with the contractor's inability to be able to comply with contract requirements and meet deliverable schedules. That frustration grew to the point where they decided not to renew the contract with CGI and instead to move to a different solution, which is to award the contract to Accenture.

So those are our three findings. We have a series of recommendations to address some of the issues. And I would be delighted to get into the specifics of that as the hearing goes forward.

[The prepared statement of Mr. Woods follows:]



United States Government Accountability Office

Testimony

Before the Subcommittee on Oversight  
and Investigations, Committee on  
Energy and Commerce, House of  
Representatives

For Release on Delivery  
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HEALTHCARE.GOV

Contract Planning and  
Oversight Practices Were  
Ineffective Given the  
Challenges and Risks

Statement of William T. Woods  
Director, Acquisition & Sourcing Management

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Chairman Murphy, Ranking Member DeGette, and Members of the Subcommittee:

I am pleased to be here today as you examine implementation of the Patient Protection and Affordable Care Act (PPACA). A central provision of the Act required the establishment of state health insurance exchanges, now commonly referred to as marketplaces. Marketplaces permit individuals to compare and select private health insurance plans. For states that elected not to establish a marketplace, PPACA required the federal government to establish and operate a federal marketplace, which users access via the website Healthcare.gov. The Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS) was responsible for designing, developing, and implementing the information technology systems needed to support the federal marketplace. CMS largely relied on contractors to develop, build, and operate the necessary information technology systems. CMS's role includes acquisition planning, contract management, and oversight of the contractors. As of March 2014, CMS reported obligating \$840 million for the development of Healthcare.gov and its supporting systems.

When initial enrollment began on October 1, 2013, many users of the Healthcare.gov website experienced problems such as website failures, errors, and slow response times. Given the high degree of congressional interest in the development, launch, and other issues associated with the federal marketplace, GAO is conducting a body of work in this area. Our report on contracting for Healthcare.gov is being issued today.<sup>1</sup> That report and my testimony this morning focus on (1) CMS acquisition planning activities; (2) CMS oversight of cost, schedule, and system capability changes; and (3) actions taken by CMS to identify and address contractor performance issues.

For our review, we selected two task orders and one contract, which together accounted for more than 40 percent of the total CMS-reported obligations related to the development of Healthcare.gov and its supporting systems as of March 2014. We evaluated the task order issued to CGI Federal Inc. (CGI Federal) for the development of the federally facilitated marketplace (FFM)—a system that accepts and

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<sup>1</sup> GAO, *Healthcare.gov: Ineffective Planning and Oversight Practices Underscore the Need for Improved Contract Management*, GAO-14-694 (Washington, D.C.: July 31, 2014).

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processes data entered through the website. The FFM was intended to provide three main functions: eligibility determination and enrollment, plan management, and financial management. We evaluated the task order issued to QSSI, Inc. (QSSI) for the development of the federal data services hub (data hub), which routes and verifies user information among the FFM and various external data sources, such as the Social Security Administration and the Department of Homeland Security. We also evaluated the contract awarded to Accenture Federal Services in January 2014 to continue FFM development and enhance existing functionality.

To conduct our work, we reviewed Federal Acquisition Regulation (FAR) and relevant HHS/CMS policies and guidance; analyzed contract modifications, contractor deliverables, and contractor monthly status reports; identified monitoring requirements; and analyzed contract file documentation. Finally, we interviewed CMS contracting officials, CMS program officials, and the contractors to obtain their perspectives. A more detailed description of the scope and methodology used for our study is provided in appendix I of our report. We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In summary, we found that CMS undertook the development of Healthcare.gov and its related systems without effective planning or oversight practices, despite facing a number of challenges that increased both the level of risk and the need for effective oversight. According to CMS program and contracting officials, the task of developing a first-of-its-kind federal marketplace was a complex effort that was exacerbated by compressed time frames and changing requirements. In an effort to be expedient, CMS issued task orders to develop the FFM and the data hub systems when key technical requirements were still unknown—including the number and composition of states to be supported and, importantly, the number of potential enrollees. CMS contracting officials explained that meeting project deadlines was a driving factor in a number of acquisition planning activities, such as the decision to proceed with the contract award process before requirements were stable and the selection of a type of cost reimbursement contract, known as a cost-plus-fixed-fee contract, for both the FFM and data hub task orders.

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This type of contract is considered high risk for the government because of the potential for cost escalation and because the government pays a contractor's allowable cost of performance regardless of whether the work is completed. While CMS's use of the cost-plus-fixed-fee contract type may have been a reasonable choice under the circumstances, the related risks increased the need for oversight. Despite these risks, CMS did not develop a required acquisition strategy to identify risks and document mitigation strategies and did not use available information, such as quality assurance surveillance plans, to monitor performance and inform oversight.

CMS incurred significant cost increases, schedule slips, and delayed system functionality for the FFM and data hub systems due primarily to changing requirements that were exacerbated by inconsistent oversight. From September 2011 to February 2014, estimated costs for developing the FFM increased from an initial obligation of \$56 million to more than \$209 million; similarly, data hub costs increased from an obligation of \$30 million to almost \$85 million. New and changing requirements drove cost increases during the first year of development, while the complexity of the system and rework resulting from changing CMS decisions added to FFM costs in the second year. Moreover, CMS delayed key governance reviews, moving an assessment of FFM readiness from March to September 2013—just weeks before the launch—and CMS did not receive required governance approvals. As a result, CMS launched Healthcare.gov without verification that it met performance requirements.

Furthermore, because of inconsistent contractor oversight within the program office and unclear roles and responsibilities, there was confusion about who had the authority to approve contractor requests to expend funds for additional work. Our review identified approximately 40 instances during FFM development in which CMS program staff inappropriately authorized contractors to expend funds, totaling over \$30 million. This is not to say the work was not necessary; however, the work was not approved properly.

As the October 1, 2013 deadline for establishing enrollment through the website neared, CMS identified significant performance issues involving the FFM contractor, but the agency took only limited steps to hold the contractor accountable. In April and November 2013, CMS provided written concerns to CGI Federal regarding its responsiveness to CMS's direction and FFM product quality issues. In November 2013, CGI Federal responded in writing, stating that it disagreed with CMS's assertion that CGI Federal had not met the requirements in the FFM

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statement of work and that delays in CMS's establishment and finalization of requirements influenced the time available for development and testing of the FFM.

CMS was prepared to take action in August 2013 that could have resulted in withholding fee from the contractor; however, CMS ultimately decided to work with CGI Federal to meet the deadline. In September 2013, CMS program officials became so concerned about the contractor's performance that they moved their operations to the FFM contractor's offices to provide on-site direction. Ultimately, CMS declined to pay about \$267,000 in requested fees. This represents about 2 percent of the \$12.5 million in fees paid to the FFM contractor. CMS contracting and program officials stated that the contract limited them to withholding fee only as a result of rework. By the end of the task order's development period, only the FFM's plan management module was complete. Some of the elements of the eligibility and enrollment module had not been provided, and the financial management module—which includes the services necessary to accomplish financial interactions with issuers—remained unfinished.

In January 2014, CMS awarded a new contract to another firm, Accenture Federal Services, with an estimated value of \$91 million to continue FFM development. This work also has experienced cost increases due to ongoing changes such as new requirements and other enhancements. As of June 5, 2014, costs on the Accenture Federal Services contract had increased to over \$175 million, while key FFM capabilities—including the financial management module—remained unavailable. Financial management module functionality is currently scheduled to be implemented in increments through December 2014. CMS needs a mitigation plan to address these issues. Unless CMS improves contract management and adheres to a structured governance process, significant risks remain that upcoming open enrollment periods could encounter challenges.

The report we are releasing today makes five recommendations to the Administrator of the Centers for Medicare & Medicaid Services to better manage the ongoing effort to develop the federal marketplace and improve future contracting efforts. Specifically, we recommended that CMS

- take immediate steps to assess the causes of continued FFM cost growth and delayed system functionality and develop a mitigation plan designed to ensure timely and successful system performance;

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- ensure that quality assurance surveillance plans and other oversight documents are collected and used to monitor contractor performance;
  - formalize existing guidance on the roles and responsibilities of contracting officer representatives and other personnel assigned contract oversight duties, and specifically indicate the limits of those responsibilities in terms of providing direction to contractors;
  - provide direction to program and contracting staff about the requirement to create acquisition strategies, and develop a process to ensure that acquisition strategies are completed when required and address factors such as requirements, contract type, and acquisition risks; and
  - ensure that information technology projects adhere to requirements for governance board approvals before proceeding with development.

After reviewing our draft report, CMS concurred with four of GAO's recommendations and partially concurred with one. CMS's comments, along with our evaluation of them, are provided in full in our report.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions that you or other members of the subcommittee may have.

For questions regarding this statement, please contact William T. Woods at (202) 512-4841 or [woodsw@gao.gov](mailto:woodsw@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. W. William Russell, Assistant Director; Jennifer Dougherty, Elizabeth Gregory-Hosler; Andrea Yohe; Susan Ditto; Julia Kennon; John Krump; Ken Patton; and Roxanna Sun made key contributions to this statement.



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Mr. MURPHY. Thank you, Mr. Woods. We appreciate your thoroughness and your candidness.

So as you described things like inconsistent or absent oversight, you said oversight weaknesses, a lack of adherence to planning requirements compounded by acquisition planning challenges. And when Mr. Slavitt testified earlier, he said fortunately or unfortunately, the GAO report wasn't news. So as you are going through this, with regard to the oversight, did people within CMS know that these problems were brewing?

Mr. WOODS. We saw some indication that the problems were known, particularly with the CGI issues that I mentioned earlier. That was well documented, what their concerns were. Other aspects, though, Mr. Chairman, were not quite as visible. And let me point out one area. We found a number of instances—and our count was about 40—where changes were being made to the contract requirements at the direction of people that did not have the authority to do that.

Mr. MURPHY. Within CMS—

Mr. WOODS. Within CMS. These were largely—

Mr. MURPHY. When you say did not have the authority, you mean they had not discussed these with Mr. Cohen or Ms. Tavenner?

Mr. WOODS. Well, the only person within CMS that has authority to change the contract in a manner that increases the Government's obligations is the contracting officer.

Mr. MURPHY. Who was?

Mr. WOODS. I am sorry?

Mr. MURPHY. And who was that?

Mr. WOODS. I don't have the name right at my finger—

Mr. MURPHY. But what I am wondering here is do you know if—so what—the problems with the Web site—it took longer to develop it. The security wasn't a question. People had problems signing up, and with inconsistent or absent oversight. So I am wondering in some case, you are saying there was actions taken without authorization. Several dozen of these, I believe, that you documented.

Mr. WOODS. That is correct.

Mr. MURPHY. So people were making change orders, and that was leaving some problems. But there was also absent oversight. So some people in charge were not meeting, were not paying attention, were not monitoring this contract? Or they were monitoring some things and making the wrong decisions? Was it both, or one or the other?

Mr. WOODS. A combination of things. There are a number of people with different roles to play. As I mentioned, there is a contracting officer. But there was also, on the program side, a governance board review process. And that process was designed to provide high level management oversight. And what we found there was that that process simply did not work as intended.

Mr. MURPHY. Now, we also had heard that there was a McKinsey Report commissioned by then Secretary Sebelius which made it pretty clear they weren't going to meet their deadlines. Did they know within CMS that these deadlines couldn't be met, and that under the pressure which you had listed such as the January 1

deadline, or the complexity of this, did they know that this really wasn't ready for prime time?

Mr. WOODS. We found some indication in the files that we reviewed that in the spring timeframe, the spring of 2013, that estimates were made that the federally facilitated marketplace would only be 65 percent complete by the October 1 deadline.

Mr. MURPHY. So they knew then in the spring. Did they know that in August and September?

Mr. WOODS. The state of knowledge continued to progress from the spring through the end of the summer. And they became increasingly concerned that the deadline would not be met. One of the principal oversight functions and processes that we saw, and that we were very concerned about, is there was supposed to be, according to the original schedule, an operational readiness review conducted in the spring of 2013. That operational readiness review was moved from the spring to the fall, to September of 2013, just weeks before—

Mr. MURPHY. And when they did that review, did they know it wasn't going to work?

Mr. WOODS. Well, as I said, there was some indication in the files that they thought only 65 percent would be complete.

Mr. MURPHY. So when Ms. Tavenner—

Mr. WOODS. The purpose of that operational readiness review is to either confirm that the system will work or find out what is wrong.

Mr. MURPHY. So when—

Mr. WOODS. So that there is enough time to fix it.

Mr. MURPHY. So when Ms. Tavenner came before this committee, or more specifically when Mr. Cohen came before this committee within days of the launch, and he said everything was going to be fine by October 1, what you are saying to this committee is there was ample evidence to say that was not true?

Mr. WOODS. We saw some indication that there was progressively increasing knowledge that there were problems in meeting that launch date.

Mr. MURPHY. OK. And did Mr. Cohen know that?

Mr. WOODS. I don't know that.

Mr. MURPHY. But either through lack of oversight, he should have known it, or he knew it and reported to this committee under oath that everything was fine, and August 1, it was going to be ready for launch? What you are telling us, there was ample evidence in what is reviewed that people within HHS knew it was not ready, and people under oath told this committee something entirely different?

Mr. WOODS. Yes. I don't know what specific individuals knew or did not know. But we saw evidence in the files that we reviewed that there was a knowledge within the Agency that the operational readiness was in jeopardy.

Mr. MURPHY. Thank you. I am over time. I will now turn to Ms. DeGette for 5 minutes.

Ms. DEGETTE. Well, this is an important issue. So you are saying people within the Agency knew that the Web site was not ready, correct? Yes or no?

Mr. WOODS. We did—we saw evidence in the files—

Ms. DEGETTE. You saw yes that people—do you think that people in the Agency knew that the Web site would collapse on October 1, yes or no?

Mr. WOODS. I can't speak to that particular characterization.

Ms. DEGETTE. You don't have any—do you have indication from the files that people in the Agency knew that the Web site would not work on October 1?

Mr. WOODS. Yes, we saw that. Yes.

Ms. DEGETTE. Can you produce that to this committee, please?

Mr. WOODS. There was a series—

Ms. DEGETTE. No, can you produce it—

Mr. WOODS. Absolutely, ma'am. Yes.

Ms. DEGETTE. Thank you.

Mr. WOODS. Yes, ma'am.

Ms. DEGETTE. Now, my next question, because Ms. Tavenner and Mr. Cohen did come in here and testify under oath several days before, as the chairman has said, that the Web site would work. Do you have evidence in your files that Mr. Cohen or Ms. Tavenner knew that this Web site would not work, yes or no?

Mr. WOODS. No, I cannot speak to the knowledge of any individual.

Ms. DEGETTE. Thank you. Now, in your opening statement, you talked about some provisions the GAO was coming up with to strengthen the Web site for—some recommendations for privacy and security concerns, is that correct?

Mr. WOODS. Well, this particular report that we are speaking to today just deals with the contracting aspect—

Ms. DEGETTE. Right. But you talked about—

Mr. WOODS. Not—

Ms. DEGETTE. But—

Mr. WOODS. Not for security and privacy. That—

Ms. DEGETTE. OK. So you are not looking at privacy and security?

Mr. WOODS. Other teams within GAO are looking at—

Ms. DEGETTE. Are looking—

Mr. WOODS. At that work—

Ms. DEGETTE. Are you aware of any security breaches in the Web sites, yes or no?

Mr. WOODS. No, I am not.

Ms. DEGETTE. OK. Now, the GAO made five recommendations you reference in your opening statement to CMS to avoid the mistakes that you had identified, is that correct?

Mr. WOODS. Yes.

Ms. DEGETTE. And I just want to go through those recommendations, because you said we should. And I think it is important to know. The recommendations I think are good recommendations, but they are a little vague. And so I am going to ask you about each one of them if you have specific details. But then also, I am going to ask you, Mr. Woods, to supplement your testimony and provide to this committee, and to CMS, specific details on each one of them. Because I think it is important for the CMS to actually be able to implement these recommendations. And our last witness said he agreed with the recommendations, and he did want to implement them.

The first recommendation is that CMS should take steps to assess the causes of the increase in cost of the continued development of Healthcare.gov and the delays in functionality of the Web site, and develop a plan to mitigate those costs and delays. Can you briefly give us a little more detail on what steps the GAO believes CMS should take to make those assessments?

Mr. WOODS. Certainly. We did see cost increases in the Accenture contract, the current contract—

Ms. DEGETTE. So what steps do you think CMS can take to rectify these problems?

Mr. WOODS. We think that they need to step back and identify the causes, the reasons why costs continue to increase, in that particular contract.

Ms. DEGETTE. OK. And do you have any thoughts what should be included in a mitigation plan?

Mr. WOODS. They need to make sure that costs are under control, and that the schedule can be met.

Ms. DEGETTE. Yes. I think those two things are key. Now, the next thing the GAO recommends is that quality assurance surveillance plans and other oversight documents are collected and used to monitor contract performance. How can those documents be effectively used to monitor performance?

Mr. WOODS. The quality assurance surveillance plan is a standard document that is required in most efforts of this size that provides a roadmap for how the Agency—any agency—is going to oversee the contractor's performance.

Ms. DEGETTE. Right. Does the GAO have thoughts on how it can be used to do that?

Mr. WOODS. Yes, it—

Ms. DEGETTE. OK. If you can give us that information, that would be great.

Mr. WOODS. Certainly.

Ms. DEGETTE. I want to go through your other recommendations briefly while I still have time.

Mr. WOODS. Certainly.

Ms. DEGETTE. The GAO also recommends that CMS formalize existing guidance of the responsibilities of personnel assigned oversight duties. So as I understand it, the roles and responsibilities were spelled out in some way. How would formalizing existing guidance prevent confusion about the responsibilities and authority going forward?

Mr. WOODS. This gets to the issue of unauthorized individuals making changes.

Ms. DEGETTE. OK. Great.

Mr. WOODS. And when they learned of that, there was internal guidance provided to all of the people that—but that has not been institutionalized. It has not been made part of the permanent guidance at—

Ms. DEGETTE. OK. OK. So they already have a way they are doing it? That just needs to be formalized?

Mr. WOODS. It needs to take the next step.

Ms. DEGETTE. Perfect. Now, the next thing, you recommend giving staff direction on acquisition strategies and developing a proc-

ess to ensure that acquisition strategies are completed on time. Can you flesh that out a little bit for us?

Mr. WOODS. That was a very important deficiency that we identified, is that there were a number of steps that CMS took to expedite the rollout of Healthcare.gov.

Ms. DEGETTE. Yes.

Mr. WOODS. But each of those individual steps added risk to the process. And the purpose of the plan, of the acquisition strategy, is to first of all identify those risks to be able to come up with a plan to address them. And we found that that acquisition strategy was not prepared.

Ms. DEGETTE. Right. So does GAO have some ideas what this process could look like if done appropriately?

Mr. WOODS. The process is already in place.

Ms. DEGETTE. OK.

Mr. WOODS. The regulations at HHS are very clear.

Ms. DEGETTE. OK.

Mr. WOODS. In fact, there is a template. It just wasn't done in this particular case.

Ms. DEGETTE. Oh, great. So they just need to follow the existing way. Perfect.

Mr. WOODS. Exactly.

Ms. DEGETTE. Last, you recommended ensuring that information technology projects adhere to the requirements for governance board approvals before proceeding with development. What exactly does that mean? What governing board are you referring to? What are the requirements? And why did the board approval process fail the first time around with Healthcare.gov?

Mr. WOODS. Yes. The Agency had a system in place that provided for an oversight board to review the progress of the system. The problem that we found is that those governance board meetings were held with incomplete information, and that decisions were not made as we would have expected to either approve, disapprove, or make modifications in the—

Ms. DEGETTE. So what you are saying is once again, this was a failure to follow the existing rules that they had?

Mr. WOODS. There was a process in place. They did not follow it.

Ms. DEGETTE. Thank you. Thanks for your indulgence, Mr. Chairman.

Mr. MURPHY. Yes. I now recognize Mrs. Ellmers from North Carolina for 5 minutes.

Mrs. ELLMERS. Thank you, Mr. Chairman. Thank you, Mr. Woods, for being with us today. And as I am sitting here listening to your report findings, I am incredibly amazed by the inefficiency that went forward with a plan of action that was in place. And I keep coming up with the same question of why? Why were these steps taken? Why was action taken the way that it was? Why were there unauthorized individuals making decisions? But I think one of the most glaring questions that I have, based on your findings, is that—and you use the word that they expedite, they took measures to expedite the rollout, that that added risk, obviously. And that was a failed strategy, essentially. Why in your opinion, based on your findings, did they stay with that October 1 rollout date

when they knew, based on what I am listening to, that it was not going to be accurate and successful, and that it would be a failure?

Mr. WOODS. Well, the law itself, the Affordable Care Act, set a hard deadline of January 1, 2014.

Mrs. ELLMERS. Um-hum.

Mr. WOODS. And they needed to have some period where consumers could determine their eligibility, look at plan availability and make decisions about what plans they wanted to choose by that January 1 date.

Mrs. ELLMERS. Um-hum. So they stuck with the October 1 date knowing that their time was running out, so now, this is me just again trying to process why they would go forward with something that obviously was not put together well, and the steps were taken—it wasn't an efficient system. And yet they were moving forward. So based on your knowledge, they had to go forward with that October 1 date so that they could have the enrollee numbers that they were looking for by January 1, regardless of the fact that it wasn't going to work?

Mr. WOODS. That has been CMS' position is that they needed to stick with that October 1—

Mrs. ELLMERS. So they had to stick to that date, because they needed those numbers of individuals signing up essentially, yes?

Mr. WOODS. Well, they needed to comply—to have a system in place by January 1 in order to comply with the Affordable Care Act.

Mrs. ELLMERS. Right. OK. So I am going to go back to some of the questions also on the tech surge—when the tech surge was implemented. To the best of our knowledge, and based on your report findings, we understand that there was a, again, tech surge in October to fix the site after Healthcare.gov's failed October 1 launch. Based on your investigation, what actions did CMS take in October to fix the site?

Mr. WOODS. In October, they continued to work with CGI Federal.

Mrs. ELLMERS. Um-hum.

Mr. WOODS. But the level of frustration reached the point in November of 2013 where they sent yet another letter detailing the shortcomings of the contractor, asking for a corrective action plan. CGI responded to that, and clearly disagreed with CMS' assessment at that point.

Mrs. ELLMERS. OK. So they were disagreeing with it. So was CGI—I mean, because there were other contractors involved, too, is that correct?

Mr. WOODS. There were many other contractors involved.

Mrs. ELLMERS. Yes.

Mr. WOODS. Correct.

Mrs. ELLMERS. OK. But particularly, it was CGI that is where the frustration was—where the disconnect was?

Mr. WOODS. They were responsible for the heart of the system, if you will.

Mrs. ELLMERS. OK.

Mr. WOODS. And that is where most of the dollars were in terms of contract expenditures.

Mrs. ELLMERS. Um-hum. So to that point, based on the fact that CGI was the main contractor for that, were there other contracts—was their contract extended? Were there any new issued contracts based on the frustration that CMS had?

Mr. WOODS. The CGI contract had been extended earlier until February of 2014.

Mrs. ELLMERS. And that was before October 1?

Mr. WOODS. I believe that was before October—

Mrs. ELLMERS. OK. So it was already extended before October 1?

Mr. WOODS. That is correct.

Mrs. ELLMERS. OK. Then to that point, were there any other contractors that were selected, knowing that CGI was not necessarily doing what was necessary for the repair of the Web site?

Mr. WOODS. The only contract that I am aware of is the new one to Accenture to continue with development of the federally facilitated marketplace.

Mrs. ELLMERS. Accenture. And can you refresh my memory on when that actually took place, when that new contract went forward?

Mr. WOODS. That was January of 2014.

Mrs. ELLMERS. That was January. OK. Well, Mr. Chairman, I have gone over on my time, and I apologize. Thank you. Thank you, Mr. Woods.

Mr. MURPHY. Thank you. I now am going to recognize the gentleman from Virginia, Mr. Griffith, for 5 minutes.

Mr. GRIFFITH. Thank you so much for being here today. I appreciate it very much.

The report indicates that CMS did not engage in effective planning or oversight. What do you recommend they do in the future to make sure they have proper planning and oversight, because they apparently dropped the ball?

Mr. WOODS. They have the tools in place.

Mr. GRIFFITH. OK.

Mr. WOODS. One of the primary tools is a strategic plan. An acquisition strategy is what it is called. There is actually a template in the HHS' regulations for each of the areas that need to be addressed. And fundamentally, it is a tool designed to identify the risks that the Agency is undertaking, and to be able to come up with a plan to be able to mitigate those risks. But they did not follow it. So the tools are there. They did not use the tools that were there.

Mr. GRIFFITH. Now, I might ask you an open-ended question because I think it is important that we get this perspective from time to time. And that would be out of the report, what have we not asked you about that we probably should have asked you about, or the people watching this at home, something that they ought to know about your report that you haven't already covered in your testimony here today?

Mr. WOODS. Well, one thing that comes to mind is the next enrollment period.

Mr. GRIFFITH. Um-hum.

Mr. WOODS. I think people are wondering, are we going to experience similar problems, or are we in better shape? And that is why we have one of our recommendations that is focused on the current

contract with Accenture where we have seen some cost growth, and we think the Agency needs to make an assessment of why that cost growth has occurred, whether they are in fact on schedule, and whether there are any risks to the 2015 enrollment period.

Mr. GRIFFITH. And my hearing is not as good as it should be. You are talking about the cost growth—what was that phrase you used?

Mr. WOODS. Cost increases. We—

Mr. GRIFFITH. OK.

Mr. WOODS. And we have somewhat of a disagreement with the Agency about the term “cost growth.” And that is why I am reluctant to use it. Their position is that any cost increase since about April of this year is totally based on new requirements, so it is unfair to call that cost growth. Our position is that when you look—before that, when they initially awarded that contract at an estimated value of \$91 million, and now it is at 175—that the Agency needs to make an assessment about why those costs increased from the 91 to the 175.

Mr. GRIFFITH. What—

Mr. WOODS. And let me just add that may not—that is not the end of it. That contract continues in place today. Our numbers are dated in terms of, you know, we completed our audit work a couple of months ago. So costs on that particular contract are almost certainly higher today than they were at the time that we completed our audit work. And we think the Agency needs to make an assessment about why costs continue to grow.

Mr. GRIFFITH. Well, I think they do, as well. And I appreciate you raising that point. And it is kind of interesting, it would seem to me some of those new requirements are probably because it didn’t work the first time around, wouldn’t you agree?

Mr. WOODS. There are enhancements to the system.

Mr. GRIFFITH. Um-hum.

Mr. WOODS. They are constantly changing and trying to make improvements to the system. The ones that—early on, I think you are right that those are related to the inability of the system to function as intended originally. But the Agency tells us the more recent cost increases are due to enhancements.

Mr. GRIFFITH. All right. Well, I appreciate that. And I appreciate your testimony here today. And I am happy to yield my last 55 seconds to whomever might want it.

Mrs. ELLMERS. I will—

Mr. GRIFFITH. Mrs. Ellmers?

Mrs. ELLMERS. Thank you. Thank you. I do have one follow-up question. And it has to do with the conversation you were just having with my colleague. When we were talking about the cost increases, you had mentioned that enhancements are what has been cited as the reasoning. My question for you is, did CMS get congressional approval for the additional funding or spending, I guess I should say?

Mr. WOODS. Yes. I am not aware of what that process was at all.

Mrs. ELLMERS. So to your knowledge, and based on the report, you did not see any effort put forward to come to Congress for additional funding for spending?

Mr. WOODS. I can’t speak to that. We didn’t see it, but that wasn’t part of our review.

Mrs. ELLMERS. OK. Thank you, Mr. Woods. And thank you to my colleague for yielding.

Mr. MURPHY. Thank you. I am going to do a second round with Ms. DeGette and I. So just as a follow-up here, are you saying that CMS is not analyzing why the contract with Accenture is growing in cost?

Mr. WOODS. We don't think that they have done that fully yet.

Mr. MURPHY. This original contract, which was a cost plus contract, who signed that contract? Who is responsible for that?

Mr. WOODS. Those contracts are signed by the contracting officer. And as I said, I don't have that name in front of me.

Mr. MURPHY. Do those have to be approved by Mr. Cohen and Ms. Tavenner?

Mr. WOODS. I don't know.

Mr. MURPHY. Do you know, in their chain?

Mr. WOODS. I don't know.

Mr. MURPHY. Is that something that your study encompassed to find that paper trail or look at that?

Mr. WOODS. We did not review that, no.

Mr. MURPHY. Well, let me ask you too. You talked about the pressure of deadlines, the January 1, 2014. But a number of delays were put into place, the employer mandate or the retirement issue, enforcement of canceled plans, individual mandate to the shop plan. Should the rollout have been delayed as well?

Mr. WOODS. I am not sure about that. But your observation about delays is accurate. When they realized that they would not be able to be fully functional by October 1, they did make some tradeoffs and pushed projects that they thought they were initially going to be able to complete by October 1, pushed that off into the future. And the small business program that you mentioned is one of them. The financial management module was also pushed off until a later date.

Mr. MURPHY. But none of those delays caused a delay in the Web site? Many of things that are mentioned, they didn't cause a delay in the Web site readiness? These several dozen other changes internally which were one of the factors in delay in the Web site readiness, though, am I correct?

Mr. WOODS. Well, the Web site was launched. I am not sure—

Mr. MURPHY. Well, you had said a number of decisions made during I guess this 2013 to 2012, were part of the complexity that—you mentioned a couple things. One, there wasn't proper oversight of the contract. And the second thing, a number of internal changes were made by someone who didn't have the authority to make those changes.

Mr. WOODS. That is correct.

Mr. MURPHY. So do you know, or can you find out for us, in terms of, if someone is making these changes, who approved the decision for them to these changes, or who gave that person the authority to be in that position to make those changes? Do you have that information?

Mr. WOODS. There are a number of people working with the contractors on a day-to-day basis. And the 40 instances of changes, or direction to the contractor, were made by multiple individuals. Some of these were technical people, as I said, working side-by-side

with the contractor. Some of them were more senior officials. All of the changes though ultimately were ratified by the person with authority to do that, and that is the contracting officer.

Mr. MURPHY. But what, did it go to the level of Ms. Tavenner or Mr. Cohen?

Mr. WOODS. I don't know.

Mr. MURPHY. Is that something your records could reveal? This is a follow-up to what Ms. DeGette was asking as well. We need to know if your records show, or if you can find out for us—I don't think—you have an excellent investigation. But it is very important to know this, if they knew or should have known in terms of approving these changes, or being aware that the Web site wasn't ready, or—well, just let me ask that part. Do you have any information on those?

Mr. WOODS. Well, as I said, we will certainly review our materials and provide an answer to that question.

Mr. MURPHY. Because it comes to this point, this committee, members of each side of the aisle has different points of view on issues with regard to healthcare reform. That is fine. That is part of what makes our Nation great. People have differences of opinion, they move forward on that. But there are certain standards within a committee that I think we should be unified in understanding that if someone comes before this committee under oath and claims that something is ready to roll out on October 1, that everybody should be able to sign up, knowing full well that it is not, it is either incompetence, it is dereliction of duty, it is sloppiness, it is lack of supervision oversight, or it is perjury to this committee. It is perjury in terms of making a claim they know is not true, or making the claim they have no business of making. The only answers to questions like is the Web site ready October 1 are yes, no or I don't know. Anything beyond that, when the claim was made by Mr. Cohen to this committee under oath that October 1, everybody would be ready to sign up, it is clear from your investigation and your testimony that people within the agencies knew it was not ready. So any information you could provide us that tells us if they knew and made false claims to this committee, or if they didn't know and made false claims to this committee, it is important for the integrity of this committee to let us know. And if you could submit that information to this committee, I would be grateful, your papers and other reviews of that.

Ms. DeGette, you are recognized for 5 minutes.

Ms. DEGETTE. Thank you very much, Mr. Chairman. And, Mr. Woods, I can understand why the Chairman is concerned about this, based on your testimony today. So I want you to think very clearly about what your investigation found and what you have testified to this committee today when I asked you these questions, because I don't want the record to be confused. And I don't want a misimpression to be left.

Are you aware of either Ms. Tavenner or Mr. Cohen coming before this task committee and lying about whether they knew that the Web site was not ready?

Mr. WOODS. No, I cannot speak to that. I don't know.

Ms. DEGETTE. You don't know. Do you know whether Ms. Tavenner or Mr. Cohen personally knew that the Web site was not ready, yes or no?

Mr. WOODS. No, I do not know.

Ms. DEGETTE. You don't know that. Do you know whether Ms. Tavenner or Mr. Cohen specifically approved those changes?

Mr. WOODS. No, I do not know.

Ms. DEGETTE. You don't know that either.

Mr. WOODS. No.

Ms. DEGETTE. Do you know who within the Agency did approve those changes?

Mr. WOODS. Ultimately, those changes were ratified and approved by the contracting officer.

Ms. DEGETTE. The contracting officer. So you could give us that information, who that was?

Mr. WOODS. Absolutely. Yes.

Ms. DEGETTE. Thank you very—I just think—and I know the Chairman agrees. We don't want to loosely be throwing around allegations of perjury or anything else when we know—and we don't want to put words in your mouth either. So I think we are clear on that.

There is one more thing I wanted to clarify about your testimony today. Your first recommendation that in your report on this topic, as we discussed, was take immediate steps to assess the causes or continued FFM cost growth and delayed system functionality, and develop a mitigation plan designed to ensure timely and successful system performance. Is that right?

Mr. WOODS. That is correct.

Ms. DEGETTE. And that is the one you are concerned about CMS following as they look at implementation of the 2015 program, is that correct?

Mr. WOODS. The effort that is underway by Accenture is to move the development forward to be ready for the 2015—

Ms. DEGETTE. Right. And that relates to that recommendation?

Mr. WOODS. Yes, it does.

Ms. DEGETTE. OK.

Mr. WOODS. We think—

Ms. DEGETTE. And—

Mr. WOODS. We—

Ms. DEGETTE. What?

Mr. WOODS. We think that CMS needs to make that assessment in order to ensure itself it is on track for that enrollment period.

Ms. DEGETTE. Right. For next year. Right.

Mr. WOODS. Right.

Ms. DEGETTE. Now, you were sitting here I believe when we heard the testimony of the previous witness, is that correct?

Mr. WOODS. Yes, I was.

Ms. DEGETTE. Mr. Slavitt. And I specifically asked Mr. Slavitt if he had reviewed the five recommendations GAO had made. Do you remember hearing that?

Mr. WOODS. Yes.

Ms. DEGETTE. And do you remember hearing Mr. Slavitt say that CMS agrees with all five of the recommendations? Do you remember hearing that?

Mr. WOODS. I remember hearing that, yes.

Ms. DEGETTE. OK. So I would just—you know, sometimes I like to have both the Agency witness and the GAO so that they can answer each other's issues. But I just want the record to be clear that Mr. Slavitt has said that they recognize this recommendation, they intend to comply with it. And I think, Mr. Chairman, we should follow-up and make sure that happens. Thank you. And I yield back the balance of my time.

Mr. MURPHY. OK. Thank you. I now recognize Dr. Burgess for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman. Mr. Woods, thank you for being here. And let me just commend the Government Accountability Office on great work. This has not been easy, and I appreciate how difficult it has been to be here today. And I appreciate your forbearance.

Now, along the lines of what Ms. DeGette was just asking you, do you know whether or not the Center for Medicare and Medicaid Services is adopting your recommendations right now?

Mr. WOODS. What they told us is that they fully agreed with four of our recommendations, and they partially concurred with our fifth recommendation.

Mr. BURGESS. Have you any evidence that you can point to that shows that in fact they are taking steps to comply with four of those recommendations?

Mr. WOODS. We have seen some indication——

Mr. BURGESS. Well, you have their assurances, but is there anything that you can point to in data and fact that they are taking those recommendations?

Mr. WOODS. What they told us is that they are providing additional training in certain areas that they plan to implement those recommendations. We are hopeful that they do. We have a normal regular process for following-up with agencies to make sure that if they tell us that they are going to implement recommendations that they in fact do so.

Mr. BURGESS. OK.

Mr. WOODS. So that process will continue at GAO.

Mr. BURGESS. Well, and I look forward to the follow-up hearing we have about that implementation.

Now, you know, a lot was written in August of 2012 about CMS' or HHS' lack of production on rulemaking as it related to the essential health benefit. And, in fact, that rulemaking was delayed. The rule actually came out about a week after Election Day that year. I don't know if you recall that. In your work, was there any evidence that that delay was politically motivated? Or am I just being overly sensitive and overly cynical by the rule coming out a few days after Election Day 2012?

Mr. WOODS. We found no indication of that, sir.

Mr. BURGESS. So your inference is I am being overly cynical?

Mr. WOODS. We found nothing to point us in that direction.

Mr. BURGESS. Well, let me just point out to you, why—on this committee, it has come up several times today. I mean, Mr. Cohen was here. I think it was about 10 or 11 days before October 1. And I asked him a very direct, very specific question. In fact, I tried to do a John Dingell and said yes or no, the Web site will be ready

on October 1? He gave me what I presumed to have been a well-rehearsed and studied answer, because he repeated it verbatim twice. And it essentially said on October 1, consumers will be able to go online, see premium net of subsidy, and make their purchase. Now, as we know, that didn't actually turn out to be the case. So it is a valid question to ask. He must have known that 10 days before the launch date, because it sounds like from your report that it was pretty clear that things weren't going well. Am I wrong about that?

Mr. WOODS. I simply can't speak to what he knew or didn't know at any particular point in time.

Mr. BURGESS. Well—

Mr. WOODS. But I can say that we found indications in the documents that we reviewed that the system was projected to be only 65 percent complete by that October 1 deadline.

Mr. BURGESS. If you had been sitting here and asked that question, and reminded that you were under oath, would you have answered it the same way Mr. Cohen did?

Mr. WOODS. I can't really respond to—

Mr. BURGESS. Well, let me ask you this, because you have got written in your report, as the October 1, 2013, deadline for establishing enrollment through the Web site neared, CMS identified significant performance issues involving the FFM, the Facilitated Federal Marketplace, contractor. But the Agency took over only limited steps. Can you provide for the committee what correspondence, what evidence, what documents you relied upon to come to that conclusion, to make that statement?

Mr. WOODS. Absolutely. We can summarize what led us to that conclusion. And we would be happy to do that.

Mr. BURGESS. As a part of making this statement, did you have access to internal emails within the Center for Consumer Information and Insurance Oversight at CMS?

Mr. WOODS. We reviewed lots of documents, contract documents, emails, memos. So we had very good access to lots of information from CMS.

Mr. BURGESS. And I appreciate that. I would simply ask that that access be made available to this committee, the documents, the emails, the transcripts that you have, would make that available to our subcommittee, for the staff—

Ms. DEGETTE. Mr. Chairman, I believe we already have that information in this subcommittee.

Mr. MURPHY. Well, let us find out.

Ms. DEGETTE. It has been produced already.

Mr. BURGESS. Again, I would ask that we be certain that you have produced the information the subcommittee staff is asking for.

Mr. WOODS. We would be happy to work with the committee on that.

Mr. BURGESS. And let me just ask you one last thing. In your opinion, is the Web site—open enrollment period this time is going to be much shorter than last time—in your opinion, are they going to be ready for the second open enrollment period?

Mr. WOODS. I am not in a position to make that judgment. That is why we had the recommendation that we did is that we think

CMS needs to make that assessment of cost and schedule to make sure that they are on track.

Mr. BURGESS. Because there is the possibility they would not be able to meet that?

Mr. WOODS. We said in the report that the risk is that there could be some impact on the 2015 enrollment period, and that is why we had the recommendation that we did.

Mr. BURGESS. OK. And I thank you for your answers.

Mr. MURPHY. The gentleman's time has expired.

Mr. BURGESS. And I thank you for being here. I yield back.

Mr. MURPHY. Thank you. I ask unanimous consent that the member's written opening statements be introduced into the record. And without objection, the documents will be entered into the record.

Mr. Woods, I want to thank you for your thorough and candid GAO report. All this committee requests is honesty, thoroughness, and details. And GAO's reputation as a nonpartisan investigative report organization is based on that ability to honestly and thoroughly provide the truth to a candid world. So we appreciate that.

Members will have several questions for follow-up. We do ask that you respond to them in a quick manner. We also ask your commitment that you will share your work with our majority and minority staffs, so they can also review them with you and get other details.

So in conclusion, I would like to thank all the witnesses and members that participated in today's hearing. In remind members they have 10 business days to submit questions for the record.

And with that, I adjourn this hearing.

[Whereupon, at 12:53 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

**Opening Statement of the Honorable Fred Upton**  
**Subcommittee on Oversight and Investigations**  
**Hearing on "PPACA Implementation: Updates from CMS and GAO"**  
**July 31, 2014**

*(As Prepared for Delivery)*

Yesterday we learned that the price tag for HealthCare.gov is approaching \$1 billion. We also learned that the administration's poor management led to significant cost increases and an exchange that - now ten months after launch - is still not complete. We have held many hearings at this subcommittee and were told on numerous occasions by administration officials that implementation was on track, Americans could keep their health plans, premiums would not skyrocket, access to doctors would be secured, and employees would not suffer. These promises have fallen woefully short.

The second open enrollment period is now less than four months away. The administration has fallen silent on providing updates to the American people about the status of implementation - but we have not stopped asking questions. We are here today to discuss whether HHS has learned from its mistakes and is taking appropriate action.

The cost of the administration's management failures is significant. Not only did this health care law cost millions of Americans their health care plans, access to their doctors, and increased health care premiums - but it is also costing them their hard-earned taxpayer dollars. According to GAO, the costs for the new website contractor have almost doubled in just 6 months - and that work is still not even finished.

Today, Andy Slavitt, the newly named Principal Deputy Administrator for CMS, will testify for the first time in his current position. I hope Mr. Slavitt can explain what HHS is doing to rein in these ballooning costs. I also hope he can honestly explain what American families can expect when open enrollment begins this November.

We're looking for straight answers to basic questions about readiness for the next open enrollment period, the status of the HealthCare.gov build, and what consumers should expect. We want the facts about HealthCare.gov contracting, application inconsistencies, and what HHS is doing to ensure mistakes aren't repeated, even more taxpayer money isn't wasted, and all agency actions are lawful.

Mr. Slavitt and Mr. Woods - Thanks to you both for being here today. We look forward to hearing from you.

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**Statement for the Record**

**Representative G. K. Butterfield**

Committee on Energy and Commerce  
Subcommittee on Oversight and Investigations

Hearing on “PPACA Implementation: Updates from CMS and GAO”

July 31, 2014

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49 years ago yesterday, then-President Lyndon Johnson signed into law two of the most expansive and important health-related programs the country had ever seen – Medicare and Medicaid. The Affordable Care Act is the most significant and consequential healthcare program since then.

But the Supreme Court weakened the ACA benefits for low-income Americans by making Medicaid expansion voluntary. Twenty-four states, including North Carolina, have disenfranchised millions and denied federal dollars they rightly deserve by not expanding. 500,000 North Carolinians have been denied coverage. Expanding Medicaid could save my state \$65 million over eight years and add \$1.5 billion to the state's revenue.

More importantly the decision by North Carolina Governor Pat McCrory and the Republican-led state legislature has cost a woman her life. Pungo Hospital located just outside of my Congressional district in Belhaven has closed its doors because North Carolina refuses to expand Medicaid. Portia Gibbs was 48 years old. She had a heart attack and died on her way to the nearest open hospital an hour away.



## THE COMMITTEE ON ENERGY AND COMMERCE

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### Memorandum

July 29, 2014

To: Members, Subcommittee on Oversight and Investigations

From: Majority Committee Staff

Re: Hearing on "PPACA Implementation: Updates from CMS and GAO"

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On Thursday, July 31, 2014, at 9:15 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing examining the implementation of the Patient Protection and Affordable Care Act (PPACA).

#### **I. Witnesses**

- Andy Slavitt, Principle Deputy Administrator, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services; and
- William T. Woods, Director, Acquisition and Sourcing Management, Government Accountability Office.

#### **II. Background**

The Subcommittee on Oversight and Investigations last heard testimony from the Center for Consumer Information and Insurance Oversight (CCIIO) on the implementation of the PPACA in January 2014.<sup>1</sup> The Subcommittee traditionally has heard updates from administration officials on the implementation of the PPACA, in particular the law's changes to the private insurance market. At past hearings, the Subcommittee has discussed the waivers granted to entities that could not comply with the PPACA's prohibition on annual limits, the Pre-Existing Condition Insurance Plan, the Early Retiree Reinsurance Program, as well as the implementation of the health insurance exchanges and HealthCare.gov. At the January 2014 hearing, the Director of CCIIO informed the Subcommittee that the back end systems of HealthCare.gov had still not been built.

Earlier this summer, Andy Slavitt was hired as the Principle Deputy Administrator of the Centers for Medicare and Medicaid Services (CMS). Mr. Slavitt will appear on Thursday to provide the Subcommittee with an update on the work that is ongoing and what the Congress can expect in the coming months. News reports indicate that in his new role, Mr. Slavitt will have

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<sup>1</sup> <http://energycommerce.house.gov/hearing/2014-seeking-ppaca-answers>

Majority Memorandum for the July 31, 2014, Subcommittee on Health Hearing  
Page 2

responsibilities that involve PPACA, Medicare, and Medicaid.<sup>2</sup> The next open enrollment period for purchasing a qualified health plan on the exchanges will be from November 15, 2014 until February 15, 2015.<sup>3</sup> Considering the technical problems with HealthCare.gov that the Subcommittee has reviewed in the past, Mr. Slavitt will be able to provide an update on the website and whether the backend systems that will handle payment processes in the future will be ready for the next open enrollment period. The administration, earlier this year, announced that they were encountering significant problems with inconsistencies in the applications submitted via HealthCare.gov.<sup>4</sup> The administration and a contractor have been working to resolve these problems.

The Government Accountability Office (GAO) also will testify on Thursday on their most recent review of CMS' implementation of the PPACA. Numerous congressional committees and offices asked GAO to review the processes and procedures that led to the bungled HealthCare.gov rollout. Tomorrow, GAO will release a report on their review of some of the contracts and task orders related to the development and launch of HealthCare.gov. GAO assessed CMS' oversight of the website and the actions taken by the administration to identify and address contractor performance issues.

There are numerous other areas unrelated to HealthCare.gov that CMS will be able to address during the hearing. With open enrollment approaching soon, consumers will be able to learn the premiums they will pay for plans offered in 2015. As insurers get ready for 2015, the administration also will be able to provide an update on the increase or decrease of competition in the exchanges. Last week, the administration also posted drafts of the forms employers will have to fill out to comply with the employer mandate, which may signal that it finally will begin to enforce the employer mandate in 2015.

### **III. Issues**

The following issues will be examined at the hearing:

- Will HealthCare.gov be ready for the next open enrollment period?
- When will the backend systems for the Federally-Facilitated Exchange be completed?
- Has the administration fixed the inconsistencies that were contained in applications submitted via HealthCare.gov?
- What premium rates can consumers expect next year?
- What can the public expect when the employer mandate is finally enforced?

<sup>2</sup> Alex Wayne, *U.S. Hires UnitedHealth's Slavitt to Lead Obamacare Effort*, BLOOMBERG, Jun 20, 2014.

<sup>3</sup> <https://www.healthcare.gov/glossary/open-enrollment-period/>

<sup>4</sup> Amy Goldstein and Sandhya Somashekhar, *Federal health-care subsidies may be too high or too low for more than 1 million Americans*, WASHINGTON POST, May 16, 2014.

Majority Memorandum for the July 31, 2014, Subcommittee on Health Hearing  
Page 3

- What did GAO find during its review of the contracting process that led to HealthCare.gov?
- What does GAO recommend to prevent the problems that led to the failed launch of HealthCare.gov from recurring in the future?

**IV. Staff Contacts**

If you have any questions regarding the hearing, please contact Sean Hayes or Emily Newman at (202) 225-2927.

FRED UPTON, MICHIGAN  
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA  
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS  
**Congress of the United States**  
**House of Representatives**  
COMMITTEE ON ENERGY AND COMMERCE  
2125 RAYBURN HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515-6115  
Majority (202) 225-2927  
Minority (202) 225-3641

August 22, 2014

Mr. Andrew Slavitt  
Principle Deputy Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Mr. Slavitt:

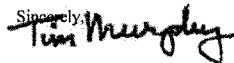
Thank you for appearing before the Subcommittee on Oversight and Investigations on Thursday, July 31, 2014, to testify at the hearing entitled "PPACA Implementation: Updates from CMS and GAO."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Friday, September 5, 2014. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to [brittany.havens@mail.house.gov](mailto:brittany.havens@mail.house.gov).

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,  


Tim Murphy  
Chairman  
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

**Andrew Slavitt's Hearing  
"PPACA Implementation"  
Before  
Energy & Commerce Committee  
Oversight & Investigations Subcommittee**

July 31, 2014

**Attachment 1—Additional Questions for the Record**

**The Honorable Bruce Braley**

1. Mr. Slavitt, as you are aware, I and many members are very interested in the proper implementation of Section 2706 of the Affordable Care Act, which addresses provider non-discrimination. As you are also aware, I recently joined more than 40 of my colleagues here in the House in a letter to the Secretary urging the Department to rectify the flawed FAQ guidance on 2706 issued over a year ago and to implement the statute as intended. Just last week, the Senate Appropriations subcommittee on Labor/HHS issued a report to accompany their funding bill for fiscal year 2015, a section of which stated that CMS has not followed a previous congressional directive to fix the FAQ and a certain date was given to fix the FAQ or explain to Congress why CMS is ignoring congressional intent in this respect.

- a. Mr. Slavitt, can you explain to the Subcommittee why CMS continues to ignore congressional intent on Section 2706?

**Answer:** As you know, on April 29, 2013, the Departments of Labor, Health and Human Services, and the Treasury (the Departments) issued a Frequently Asked Question (FAQ) regarding section 2706(a) of the Public Health Service Act. Since the FAQ was issued, we have received feedback from many stakeholders, including provider groups and Members of Congress. On March 12, 2014, the Departments published a Request for Information regarding this provision. We requested comments through June 10, 2014, on all aspects of the interpretation of section 2706(a) of the Public Health Service Act. We received over 1,500 comments and are currently reviewing them.

**The Honorable G.K. Butterfield**

1. Apart from HealthCare.gov, it's important to recognize that this is not the only significant IT investment under CMS' purview. The most recent data on the IT Dashboard indicates that there are almost 30 investments where we're spending \$15 million dollars or more in FY 2014 – including 4 where we're spending over \$100 million in FY 2014. All too often, we're using cost-plus contract arrangements that place all the risks for cost overruns on the taxpayer and not holding contractors accountable for what they deliver.

- a. How are you ensuring that these investments are regularly delivering useful functions to end-users every six months or, at least, every year – as is the standard practice in the private sector?**

**Answer:** CMS has a number of information technology needs across all programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Marketplace. CMS is committed to strengthening its system development life cycle processes. With the increasing need to respond quickly to business demands, CMS created a structured Enterprise System Life Cycle Development process called Expedited Life Cycle (XLC) to help coordinate and develop IT projects. Consistent use of the XLC process combined with rigorous cost and schedule reporting helps to ensure that investments made through contracting result in useful deliverables. CMS also uses multiple Technical Review Boards throughout the systems development lifecycle to accelerate implementation of usable system functionality and force consideration of the use of existing public and private sector business solutions.

- b. As an example, for the top 10 investments, totaling a little over \$1.4 billion in spending for FY 2014, what functional capabilities were or will be actually rolled out to users this calendar year?**

**Answer:** Many of the larger IT investments are in mixed lifecycle status, entailing both Development/Modernization/Enhancement and Operations and Maintenance. CMS uses periodic software releases to address new business needs as determined by the investment's change control board and senior agency officials. For instance, the HITECH investment successfully implemented Stage 2 Meaningful Use criteria for Electronic Health Records, the agency's accounting system deployed the initial capability to account for Health Insurance Marketplace payments, and CMS' public websites included updated plan information and program changes to improve customer service.

- c. For these same top 10 investments, how are you incorporating existing solutions, whether from elsewhere in government or from the commercial market, that could be used to deliver useful functionality within 6 months or, at least, within a year?**

**Answer:** For each new business need, CMS relies on the principles of Enterprise Architecture to encourage re-use of existing technology and minimize duplicative efforts. Specifically, CMS promotes enterprise shared services to reduce application and data redundancy across its programs, commercial software-as-a-service tools to streamline data analysis and performance monitoring, and a cloud-computing center approved by the Federal Risk and Authorization Management Program.

- d. To the extent that you are doing this, how are you structuring contracts to incentivize success, rapid delivery of actual capabilities, and to shift risk from the taxpayer onto private industry?**

**Answer:** For larger, complex development and maintenance contracts, CMS has utilized a Cost Plus Award Fee arrangement to incentivize exceptional performance. Additionally, CMS is

placing emphasis on structuring our contracts with clearly defined deliverables and utilizing enhanced contract monitoring to track contractor performance and to identify performance issues quickly and take effective remedial action, if necessary.

- e. In particular, how are you using firm-fixed price arrangements that put more of the onus of budget and schedule control onto the contractor?**

**Answer:** CMS uses firm fixed price contracts whenever feasible. In planning for all new acquisitions, CMS determines the appropriate contract pricing arrangement after considering the unique factors associated with the requirement. When the requirements are well-defined, and the uncertainty can be predicted with an acceptable degree of accuracy, CMS uses a firm fixed price arrangement. Our firm fixed price arrangements include the acquisition of commercial items, infrastructure and hosting services, requirements support, testing services, and security support services.

#### **Attachment 2—Member Requests for the Record**

*During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.*

##### **The Honorable Tim Murphy**

- 1. Most of these plans cover an initial visit and some preventative care. Have you surveyed people to find out if they have been able to see their physicians for any necessary follow-up appointments and reviewed their costs, payment levels, copays, deductibles, etc.?**

**Answer:** Millions of Americans now have access to the health care services they need to stay healthy, and we are closely monitoring all available data to make sure consumers are benefiting as the law intended.

##### **The Honorable Michael C. Burgess**

- 1. Please provide the memorandum that I requested from Mr. Cohen.**

**Answer:** HHS has provided the memorandum and it is publicly available on the Committee's website.<sup>1, 2</sup>

<sup>1</sup><http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/letters/20140619HHSResponse.pdf>

**The Honorable Morgan Griffith**

1. Please provide the Committee with the waiver that you had to sign once becoming employed by CMS. Please explain the details of this waiver.

**Answer:** CMS is providing a copy of this waiver to your staff. The waiver is publicly available through the United States Office of Government Ethics.<sup>3</sup>

**The Honorable Renee Ellmers**

1. Please provide the Committee with any changes or updates to site protocols or standards to address breaches to accessed information.

**Answer:** No person or group has maliciously accessed personally identifiable information from HealthCare.gov. Like other consumer facing websites, HealthCare.gov is a routine target of malicious attacks, and has successfully defended against these attacks. CMS conducts continuous monitoring using a 24/7, multi-layer IT professional security team, added penetration testing, and ongoing testing and mitigation strategies implemented in real time. Security testing is conducted on an ongoing basis using industry best practices to appropriately safeguard consumers' personal information. All suspected security incidents are reported and investigations into any incidents begin immediately.

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<sup>2</sup> <http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/letters/20140619HHS-GAOResponse.pdf>

<sup>3</sup> <http://oge.gov/DisplayTemplates/SearchResults.aspx?query=slavitt>

FRED UPTON, MICHIGAN  
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA  
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS  
**Congress of the United States**  
**House of Representatives**  
COMMITTEE ON ENERGY AND COMMERCE  
2125 RAYBURN HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515-6115  
Majority (202) 225-2927  
Minority (202) 225-3641

August 22, 2014

Mr. William T. Woods  
Director  
Acquisition and Sourcing Management  
Government Accountability Office  
441 G Street, N.W.  
Washington, D.C. 20548

Dear Mr. Woods:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Thursday, July 31, 2014, to testify at the hearing entitled "PPACA Implementation: Updates from CMS and GAO."

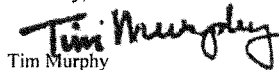
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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Tim Murphy  
Chairman  
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments



U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.  
Washington, DC 20548

September 18, 2014

The Honorable Tim Murphy  
Chairman  
The Honorable Diana DeGette  
Ranking Member  
Subcommittee on Oversight and Investigations  
Committee on Energy and Commerce  
House of Representatives

Subject: *Healthcare.gov Contracts: Responses to Questions for the Record*

On July 31, 2014, we testified before your subcommittee on contract planning and oversight practices related to Healthcare.gov contracts.<sup>1</sup> Members of the subcommittee subsequently requested that we provide responses to a number of post hearing questions. The questions and our responses are provided in the enclosure. The responses are based on work associated with previously issued GAO products. We conducted this work in accordance with generally accepted government auditing standards.

If you have any questions about this letter or need additional information, please contact me at [REDACTED] or [REDACTED].

[REDACTED]

William T. Woods  
Director  
Acquisition and Sourcing Management  
Enclosure

<sup>1</sup> GAO, *Healthcare.gov: Contract Planning and Oversight Practices Were Ineffective Given the Challenges and Risks*, GAO-14-824T, (Washington, D.C.: July 31, 2014).

**Enclosure: GAO Responses to Questions for the Record from House Energy and Commerce Committee, Subcommittee on Oversight and Investigations**

**The Honorable Tim Murphy**

**Question 1. You mentioned during the hearing that only one person within CMS has the authority to change the contract in a manner that increases the government's obligation, a contracting officer. Who is that person?**

Response: The Federal Acquisition Regulation provides that the contracting officer is the only person authorized to change the terms and conditions of the contract. It also states that other government personnel shall not direct the contractor to perform work that should be the subject of a contract modification. Large agencies such as the Department of Health and Human Services often have hundreds of contracting staff, including contracting officers, to help manage procurements. In fact, HHS reported having over 1,000 contracting staff in 2014. A contracting officer is typically a career federal employee with authority to award and administer contracts up to specified dollar values, depending on the contracting officer's level of training and experience. For the contract and two task orders we reviewed, three individuals were assigned contracting officer responsibilities during the period of performance we reviewed. Each of the contracting officers was from the Information Technology Contracts Group within CMS's Office of Acquisition and Grants Management. We would be pleased to brief committee staff, if additional details are needed.

**Question 1a. You mentioned that other individuals, who were not authorized, made these authorizations in the mentioned 40 instances instead of the contracting officer. Please provide the committee with what changes were authorized and who made each authorization.**

Response: According to contract file documents, the contractor identified 40 instances in which CMS staff approved additional items or changes within the federally facilitated marketplace (FFM). According to contractor documents, the 40 instances included changes that resulted in additional work for the following:

- eligibility and enrollment module
- plan management module
- project support
- authorizations for software licenses.

We would be pleased to provide additional details if needed. These changes were approved by staff in CMS' Office of Information Services, Center for Consumer Information and Insurance Oversight, and Office of Communications. The CMS contracting officer ultimately determined that this work was necessary and within the general scope of the task order, although the costs of the activities went beyond the estimated cost amount established in the order, thus requiring a task order modification.

**Question 1b. If someone gave these individuals authority to make these decisions, who was that?**

Response: To our knowledge, no one at CMS authorized anyone who was not a contracting officer to change contract terms and conditions. As noted in our report, however, CMS program officials described difficulties clarifying oversight responsibilities in organizations that were new to CMS. Program responsibilities were shared between CMS' Center for Consumer Information and Insurance Oversight (CCIIO), which was primarily responsible for developing business requirements, and the information technology staff in the Office of Information Service (OIS), where the government task leader and contracting officer's representative were located. CCIIO was relatively new to CMS, having been created shortly before the FFM and data hub task orders were issued. OIS program officials explained that CCIIO was not as experienced with CMS's organization and did not strictly follow their processes, including for oversight. CMS documents show that there were concerns about inappropriate authorizations identified in late 2012, as officials in the OIS acquisition group had repeatedly cautioned other OIS and CCIIO staff about inappropriately directing contractors. In April 2013, shortly after the inappropriate authorizations and related cost increases for the FFM and data hub task orders were identified, a senior contracting official at CMS sent instructions on providing technical directions to contractors to the program offices that had been involved in the authorizations and to CMS directors in general. Specifically, the program offices were reminded to avoid technical direction to contractors—particularly when there is an immediate need for critical functions—which might constitute unauthorized commitments by the government. Our report recommended that CMS formalize existing guidance on the roles and responsibilities of contracting officer representatives and other personnel assigned contract oversight duties, such as government task leaders, and specifically indicate the limits of those responsibilities in terms of providing direction to contractors. CMS concurred with this recommendation and said it is currently working to formalize existing guidance.

**The Honorable Michael C. Burgess**

**Question 1. In your report, as the October 1, 2013, deadline for establishing enrollment through the website neared, CMS identified significant performance issues involving the Facilitated Federal Marketplace (FFM) contractor. But the agency took over only limited steps. Please provide the committee with the correspondence, evidence, and documents you relied upon to come to that conclusion, to make that statement.**

Response: GAO's finding regarding the steps CMS took to address contractor performance issues is based on a variety of sources, specifically:

- A letter that CMS contracting officials sent to the contractor in August 2013, which was later withdrawn.
- A series of letters exchanged between CMS and the contractor in November 2013.
- CMS documents reflecting decisions not to pay any fee requested by the contractor for what CMS regarded as "re-work."

We can make these documents available to the committee following the conclusion of our ongoing engagements. Meanwhile, we would be pleased to brief committee staff, if additional details are needed.

**The Honorable Diana DeGette**

**Question 1. Please provide the committee with the files you referred to during the hearing that indicate that people within the agency knew that the website would not work on October 1.**

Response: During the subcommittee's hearing on July 31, 2014, GAO noted that CMS had knowledge that the system would not be fully complete by October 1, 2013. In March 2013, CMS realized that more time would be needed to develop the FFM and data hub, which were originally intended to be complete by September 2013. CMS decided to extend the period of performance of the task orders until February 2014, because officials estimated that only 65 percent of the requirements included in the FFM statement of work—and 75 percent of the requirements in the data hub statement of work—would be completed before October 1, 2013. Recognizing that neither the FFM nor the data hub would function as originally intended by the beginning of the initial enrollment period, CMS made trade-offs in an attempt to provide necessary system functions by the October 1, 2013, deadline. Specifically, CMS prioritized the elements of the system needed for the launch, such as the FFM eligibility and enrollment module, and postponed the financial module, which would not be needed until post enrollment. While CMS knew that the system would not be fully complete by the October 1, 2013 deadline and that system development and testing activities were not yet complete, we do not have evidence that CMS knew the system was insufficiently functional to launch.

We can make the evidentiary documents available to the committee following the conclusion of our ongoing engagements. Meanwhile, we would be pleased to brief committee staff, if additional details are needed.

**Question 2. Please explain how the quality assurance surveillance plans and other oversight documents can be effectively used to monitor performance.**

Response: Oversight documents such as a quality assurance surveillance plan ensure that agencies use systematic quality assurance methods to provide for government oversight of the quality, quantity, and timeliness of contractor performance. Quality assurance surveillance plans enhance an agency's ability to monitor performance by establishing metrics that are agreed upon by the agency and the contractor. The plans also outline roles and responsibilities, key measures to be assessed, the surveillance methods used to monitor performance and the process for accepting contractor deliverables. Ultimately, the quality assurance surveillance plan provides a means for evaluating whether the contractor is meeting the performance standards at the quality levels needed to fulfill contract requirements. The Federal Acquisition Regulation requires that contract quality assurance be performed as may be necessary to determine that the supplies or services conform to contract requirements.

**The Honorable G.K. Butterfield**

**Question 1. Mr. Woods, the testimony offered by Mr. Slavitt described a number of new planning and oversight changes implemented by Secretary Burwell.**

**Question 1a. Are these improvements in line with the recommendations provided by GAO?**

Response: Mr. Slavitt described CMS' plans to better manage the marketplace in part by implementing changes to enhance communications with contractors, better define requirements, and use of metrics-driven contract reviews. Such actions are in line with our recommendations. Specifically, in the response to our draft report, CMS concurred with four of our five recommendations, and partially concurred with the last recommendation, all aimed at improving the management of the marketplace. CMS partially concurred with our recommendation that CMS assess the causes of continued cost growth for the FFM contract. In their response to our draft report, CMS explained that it had already assessed the reasons for cost growth under the first FFM task order and that any increase in costs in the later contract was attributable to additional requirements, not cost overruns. GAO recognized that much, but not all, of the cost increase is due to new requirements or enhancements and we continue to believe a further assessment is needed.

CMS noted its efforts to address the remaining recommendations, including better enforcing policies and improving strategies to monitor contractor performance, formalizing guidance and improving training regarding responsibilities for providing directions to contractors, ensuring program managers understand their responsibilities for creating acquisition strategies, and adopting a governance structure to oversee development. GAO will follow and report on CMS' progress in addressing these recommendations through our ongoing recommendation review process.

**Question 1b. As CMS continues to improve oversight of contractors and their responsibilities, what tangible benefits can consumers expect to see?**

Response: If CMS successfully implements our recommendations to improve contractor oversight, such as ensuring the use of quality assurance surveillance plans, CMS should improve its ability to identify and mitigate risks that can result in cost, schedule, and performance issues. For example, use of quality assurance surveillance plans and other oversight tools such as timely governance reviews can help CMS use defined metrics to detect contractor performance issues at early stages. Such actions could allow CMS time to take corrective actions, such as withholding contractor fee if needed and make cost, schedule, or program performance changes to better ensure that program requirements and intended system functionality are delivered. In turn, this should improve the experience for consumers that use the Healthcare.gov website.

**Question 1c. The Congressional Budget Office has already updated projections and indicated the cost of implementing the ACA is less than expected. As CMS continues to strengthen its oversight of contractors, can you describe potential areas of additional savings?**

Response: CMS concurred with our recommendations to improve contractor oversight, which will contribute to its ability to ensure that requirements for remaining contracts are delivered at the expected costs, on time, and with the expected level of performance. GAO's prior work has shown that effective management can improve project results, including the avoidance of cost increases and schedule delays. For example, when requirements are well understood, agencies are in a better position to estimate costs and schedules more accurately. For remaining contracts, such information would enable CMS to develop more reasonable estimates and make better tradeoffs between cost and requirements.

